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COMMUNICATIONS.

CASE OF SUCCESSFUL SIMULTANEOUS TRIPLE AMPUTATION FOR RAILWAY INJURY, WITH REMARKS ON THE TECHNIQUE OF MULTIPLE AMPUTATION.[1]

BY JOHN ASHHURST, JR., M. D.,
PROFESSOR OF CLINICAL SURGERY IN THE UNIVERSITY OF PENNSYLVANIA; SURGEON TO THE PENNSYLVANIA AND UNIVERSITY HOSPITALS, PHILADELPHIA.

The patient is brought before the College largely on account of the rareness of simultaneous triple major amputations. It is quite possible that some of the Fellows may not have had an opportunity of seeing such a case.

The patient is a Moor, twenty years of age. He was admitted to the University Hospital, November 28, 1887, having been run over on the Pennsylvania Railroad. I saw him within two hours after his admission. I found a compound comminuted fracture of the right leg, the laceration extending above the knee; complete avulsion of the left leg, the limb having been torn off in its lower third; and a compound fracture of a severe character of the right hand and wrist. There was also a compound fracture of the skull, involving the frontal bone. This, however, was an impacted fracture, of course without much depression, and did not require interference. In addition to these injuries, there were numerous brush-burns and contusions, some of a grave character. One upon the left buttock was so severe that the separation of the slough left a cavity fully two inches in depth. Notwithstanding these serious injuries, the patient's general condition was very good; he had reacted thoroughly, and his axillary temperature was 99° F. Under these circumstances, I felt justified in proceeding to the immediate removal of the injured limbs, and amputated successively the right thigh by the antero-posterior flap method; the left leg, about its middle, by a modified Sédillot's external flap operation, the modification consisting in making both flaps from without inward, instead of cutting the external flap by transfixion; and the right forearm by an oval incision, making use of the uninjured skin of the back of the hand and wrist. Certain variations from the ordinary procedure in amputations I shall refer to when I come to speak of what I have ventured to term the technique of multiple amputations. After the operations were completed, the temperature had fallen only to 98° F. The patient had no bad symptom and rapidly recovered, and as you see him now all his wounds are perfectly healed, and he is entirely well.

I have collected some statistics of synchronous multiple amputations. I am able to find but one instance of *quadruple* synchronous amputation—a case in which the operations were done for frost-bite by Dr. George E. Jackson, of Dakota. There are several cases recorded of quadruple amputations, not synchronous, the one which approaches nearest to a synchronous operation being that of Champenois, a French surgeon, who amputated three limbs on one day, and the fourth a few days later.

Of synchronous triple amputation there have been reported four successful cases, not including that presented to-night; one by Dr. Köhler, of Schuylkill Haven, Pa.; one by Dr. Lowman, of Johnstown, Pa.; and two referred to by Professor Agnew, in his *Surgery*, one occurring in the practice of

[1] Stenographic report of a verbal communication made to the College of Physicians, March 7, 1888.

Dr. Stone, of New Orleans, and the other in York, the name of the surgeon not being given. There are reported four or five triple amputations not synchronous. I have myself resorted to synchronous triple amputation in two cases. Several years ago, I had occasion to perform this operation, removing both legs and the right forearm of a man, aged forty-five years, of intemperate habits. The patient died on the tenth day, the fatal result being due rather to the visceral lesions resulting from alcoholism than to the operation.

Double amputations are comparatively numerous. I have personally performed fifteen such operations, this number not including two successful cases of double partial amputation of the feet. I have done fifteen double major amputations, of which five have ended in recovery. One of the patients who recovered, I had the honor of exhibiting to the College some years ago; the amputations in this case were through the right hip-joint and through the left leg. In the fatal cases, seven of the deaths occurred within less than one day, and were, therefore, the immediate result of the shock of the injury and of the operation. Three patients died, one in three days, one in four days, and the third in eighteen days. The latter would probably have recovered, but that he also had suppurative disease of the middle ear, which appeared to be the cause of the pyæmia which proved fatal; for when the stumps were examined, after death, they were found to be in good condition.

With regard to what I have termed the technique of multiple amputations, there are some points which my experience justifies me in urging upon surgeons as of importance in promoting success. In the first place, it is very important that the time occupied by the operations should be brief; that the operations should be done systematically, so as to keep the patient under the anæsthetic as short a time as possible. The next point, perhaps of even more importance, is to keep up the temperature of the patient during the operations. I have been led to think that this is, perhaps, of more importance than anything else. Of course, loss of blood must be scrupulously guarded against, and loss of blood directly causes loss of temperature. In this case hot cans were kept around the patient during the entire operation; and, in order to save time, I operated systematically, the tourniquet and Esmarch bandage being both employed to prevent any loss of blood. I began with the most serious injury, and this is, I think, a point of importance. It may happen that, after the removal of one limb, it will be found that further operation must be postponed on account of the patient's condition, and then it is, of course, better to leave him with the less severe injuries. In this case, I began with the thigh. After amputating the limb, I secured the main vessels, which were readily found. I attempted to tie the arteries with catgut, but as the ligatures broke, I substituted silk, and, in order to save time, left both ends uncut. I next amputated the right leg, securing the vessels in the same manner, and then passed to the forearm. I then came back to the right thigh, screwed up the tourniquet and removed the Esmarch bandage, and secured all the vessels that required ligature, then passing to the other limbs in the same order as before. After the vessels had been secured in each case, a towel dipped in a hot antiseptic solution was placed between the flaps. The wounds were then dressed in the same order, and in this way the operation was completed in a comparatively short time.

The points which I have mentioned I believe to be of great importance, and I think that much of the disappointment of surgeons from these operations is due to a want of attention to these matters.

I should also say that, in order to preserve the bodily heat, I did not use irrigation during the amputations. I think that this often seriously reduces the temperature; and even in comparatively slight operations where it has been used, I have seen the temperature fall to 97° F., and even 95° F. I think that in any grave case, it is better to omit it and to rely upon washing with hot antiseptic solutions before and after the operation. Also, the packing of wet towels around the seat of operation, as is very commonly done, tends to depress the temperature, and in grave cases should be omitted.

I think that it is to an observance of these precautions that I have owed success in this case, and in many other serious operations of various character.

—A party of soldiers in Paris was engaged in firing blank cartridges, when one of them, Carre, put a bullet into his rifle by mistake. When the word was given, Carre, who was in the rear rank, fired with the rest, and his bullet lodged in the head of his front-rank man. The captain in charge dropped dead from heart disease when he saw the soldier fall, and Carre endeavored to kill himself, but was prevented. The bullet was successfully extracted, and the injured man will probably recover.

ESSENTIALS: NON-ESSENTIALS.

W. M. HEPBURN, M.D.,
FREEHOLD, N. J.

A feeling bordering on despair must sometimes fill the heart of every earnest student and practitioner. Difficulties meet him, both in his reading and in his efforts at the bedside, which seem insurmountable, and make him wonder just what he knows about drugs, and doubt if there is much to know. Like the able writer in the *Record*, August 21, 1886, in the article, "What Can We Cure?" who sums up his list of lithontriptics, emmenagogues, expectorants, etc., as worse than useless, and also adds: "Ringer is quoted as a believer in specific medication, while his book goes through six annual editions, yet his most vaunted remedies are for functional disorders. A good physician's highest hopes are realized when he has by opium assuaged pain, and by alcohol kept the heart wagging in the decline of some violent malady."

He even robs us of what a prominent surgeon once remarked to me, were all the drugs we could see results from, viz., iodide of potassium and mercury, quoting Diday as saying: "Syphilis is cured by the grace of God;" and he deals the final blow in these words:

> "Like blind men fighting in the dark,
> They never fail to miss the mark;
> When death doth fail, the doctor's sure
> To meekly stand and claim the cure."

It is not alone in the materia medica and therapeutical world that we are met by such truths, or partial truths. If we try to acquaint ourselves with the cause of disease, we find the same apparent difficulty in knowing just what to accept and what reject. We may give our whole belief to the theories of some brilliant writer, but that does not settle the matter. What is the truth? That is what we wish to know.

In a gathering such as the International Medical Congress, we have an opportunity to see how diametrically men differ. As I read my journal to-day in regard to pneumonia, I find one writer says: "The day is seemingly not far distant when we shall speak of pneumonic fever in precisely the same way as we use the term enteric fever at present; that is, to signify a zymotic or specific blood disease manifesting itself after the lapse of a certain time—the period of incubation—by physical phenomena, objective and subjective, connected in this instance with the lungs." Yet the very next essay is by one who thinks that nearly all of the pneumonias seem to be accounted for without the necessity of supposing a special contagion: cold, dry air, according to this writer, is the great factor in acute pulmonary inflammations.

But why multiply cases? Even in regard to bacteriology, we are informed by an authority, that the only experiments made which have given satisfactory results are those in carbuncle and tuberculosis. As the same writer says: "To conclude hastily that this or that microbe is the cause of any disease is but to ignore or set aside experimental method. The demonstration which the experimental method demands in this case would be complicated, because we would not only have to know that the microbe existed, but we would have to know what was the condition of the blood necessary to the culture of that particular microbe; and science tells us that, for the present, this is a problem we cannot solve." When the innumerable facts of our medical world face us, when we are met by such an array of truths, and attempt to even contemplate the amount of research it will necessite before we see clearly, and not through a glass darkly, we feel our helplessness, and can appreciate the old professor's view of his life which has been spent in the study of one Greek word, and which he thought had been too broad a subject.

But although we see the difficulties, yet we have patients lying on beds of suffering, and, maybe, death. Our *lack* of knowledge cannot be of benefit to them. In our ignorance what are we to do? Certainly the best thing to do is to grasp what has been given to us in the present state of medical knowledge, and to be able to appreciate what is essential, and what not. I truly believe that drugs are meant to be more than mere palliatives; that they have virtues which should make them curative, but that we will never learn what those virtues are until we have first had *preventive* measures *ground into us*. Surgeons performing operations realize the necessity of banishing everything of a contagious character; the dangers of an operation unless they are vanished, but it is hard to impress upon physicians, as a whole, especially when they have pure country air about them, that it is *the* treatment of the present time.

How many perfectly isolate cases of scarlet fever, measles, diphtheria? How many disinfect typhoid and all suspicious stools? How many rooms are thoroughly disinfected after contagious diseases?

I recall a house where last spring I attended three cases of severe attacks of scarlet fever,

in the poorer part of the town. Just while it was at its height I happened to see a large wagon filled with clothes stop there and the driver take a bundle into a room but a little distance from where the patients were all lying. This bundle of cut cloth was to be sewed and then sent back to the factory. I imagine what the result might have been had I allowed the cloth to be left. This house consisting of two rooms filled with old furniture, must have been saturated with germs. I spoke earnestly to the inmates and to one of the health authorities about having the house thoroughly disinfected. I do not think it has been done. And is it an unusual case? Are the great majority of infected houses properly disinfected?

So in another house where two of three children died of diphtheria, a neighbor came unasked and not needed, to sit where the children were. I told her to go home, and was answered that she had been with such cases before and was not afraid, yet she went directly from there to her nursing baby. What an absurdity to pour iron and potash, or any other drug down the throats of the children of such parents. We do not see results as rapidly, from proper care of cases, as does the surgeon; but just as primary union is the usual instead of the exceptional result of operating in the present day, because of vigorous attention to proper surgical surroundings, so will our mortality list be larger or smaller according to our ability to appreciate and rectify the harmful surroundings of our patients. The ignorance in regard to hygiene is appalling. A patient complained to me of his well-water tasting and smelling badly, and on investigation I found his neighbor's cesspool was only twenty-five feet away, and had been there for years. Yet this same neighbor—a man standing well in the business world as a man of sense and sagacity—was amused to think that his cemented cesspool which, though old, was twenty-five feet away, could contaminate the well.

But our knowledge is limited, and as we have diseases which, to us, are non-contagious and non-preventable, what can we do for them? Are opium and alcohol our only standbys? Immediately the fact presents itself that mere prescribing is not the whole duty of a physician. And when we speak of curing disease we connect with that expression the thought of work thoroughly done. Pure air, perfect isolation, suitable and nourishing food, good nursing. How much this means. "High and low, rich and poor, the wise man and the fool, rival in ignorance of the absolute need to health of a limitless supply of fresh, pure air. Their dainty stomachs will reject unsavory food, their delicate hands shrink from the touch of unclean things; but they will greedily and recklessly take into their lungs to be incorporated in themselves viler nuisances than any of the visible filth they have smelt or touched or tasted, for notwithstanding its æriform condition it is as much filth as the fetid ooze of the sewer or solid putrescence of decomposition." Rich and poor suffer from ignorance in most matters where the health is concerned. As one says in regard to Bobbie's eating: "Nobody thinks of refusing to give him kidney, fried potatoes, buckwheat cakes, or coffee. His mother could not decide if questioned, which of these is wholesome fare for infants * * * He lives through it? Why—yes—generally. That is, he does not always and immediately die as the unmistakable result of the poison. His system takes care of it somehow, or gets rid of it somehow else. If, by the time he is thirty, the long suffering stomach will pay no more debts of his contracting, who reckons why the trial-balance does not come out right? He lived through scarlet fever, but it left him slightly deaf; the measles kept him prisoner all of one winter, and his eyes have been weak ever since * * * Not even the always vigilant mother thinks of associating childish excesses with the lad's sick headaches or the man's defective digestion."

In spite of what we do not know how our field broadens as we contemplate our duty; what evidences we gather by simply opening our hearts to them, of the needed medical educators, oh, and how it adds to the dignity of our noble profession to be, not alone drug prescribers—even though they be specifics—but the health *preservers* in the families which we attend.

But more than this as an eminent writer says: "Indeed, the methods, even those the outcome of the most conclusive experimental science and of the most perfect mechanical treatments, must ever take cognizance that in treating the sick we are dealing with the man in disease, *quite as much* as the disease in the man. However more exact our means, however larger our resources, the personal something in the sick, the personal something in the physician will never cease to have their power. And the greatest success will always be with the greatest measure of tact, with the quickest appreciation of vital strength, with the magnetic influence which instils confidence and trust with the fullest inspiration of hope, as well as with courage that knows when to take risks and the wisdom that knows when to rest."

But there are many more facts confront us outside of care for our patients and the personal magnetism of the physician.

One of these is the question of the use and effects of drugs. One reason we do not see *direct* results from medication is because we fail to recognize the disease.

When in the Pennsylvania coal region I recall being requested, by a woman, to give her some ointment for hemorrhoids as her husband had suffered and was then suffering from them. The ointment, with advice as to care in other respects, was given. Next day I was again stopped, as I passed through the town, and requested to give something better. Fortunately I decided to go in the house and see the patient. Examining the parts and not seeing evidence of much trouble, I introduced my finger into the bowel and feeling some hard body lying across the bowel; I passed my finger above and around it (causing great pain) and pulled out a splinter of wood at least one and one-half inches long, blunt at one end and pointed at the other. The man could give no history whatever to account for its presence.

A second reason is, it is sometimes impossible to know just what causes the trouble. I have a patient, an adult, who four years ago fell while walking on the street and had a severe convulsion. It was his first and last. The heart and urine were examined, but nothing abnormal was detected, and a heavy meal was supposed to have caused the attack. A few months since he developed hemianopsia.

Thirdly, even when we detect the disease we do not always do reasonable things. It is seldom one meets a physician who cannot tell him about the latest drugs; but one cannot have much knowledge of the treatment of many doctors without being conscious of the fact that there is yet a wild search after "that specific," and often the poor sufferer is taking three or four distinct combinations, and, as I have seen, *not a teaspoonful* of nourishment.

But how is it possible to speak of the questions which present themselves to the physician in every very sick patient which he must answer for himself, which books cannot aid him in, and on his treatment may depend the life of the person. I have now a convalescent case from that common disease, acute articular rheumatism, which presented just such questions. A man about 28 years of age, German, evidently a sufferer in early life from Pott's disease. Had once before had a long, tedious attack of rheumatism. By exposure he was prostrated in December, and when I saw him he was entirely helpless. From the first he showed symptoms of great prostration. Pulse rapid and weak, breathing short and about thirty respirations to the minute, pain excessive. Gave alkalies, anodynes and food. Retained his food and medicine nicely, but the opiates caused obstinate constipation, and after some days his breath became very offensive, tongue heavily coated and dry, and vomiting threatened—which same would have made his chances few. What shall we do? I gave, with difficulty, an enema. He retained it and had no movement. A purging would cause intense pain from repeated use of bed-pan, and his prostration was too great to allow of it. Decided on one-tenth grain of calomel every hour for six hours, followed by teaspoonful doses of magnes. sulph. every four hours. Result, moist tongue, better digestion, and easy and large movement. If we do well in all such emergencies do we not assist in curing the patient?

As to the specific action of drugs, I know of no specific for any disease, but I have seen drugs act like specifics.

Certain medicines will do well in certain people, and utterly fail in others. Certain drugs will accomplish desired results when combined, when separately they are seemingly useless. I have seen persimmons and whiskey combined literally raise up a man suffering with cancer of the bowel, control a desperate diarrhœa and prostration, when stimulants with anodyne sedatives and everything else utterly failed. In other cases the combination had no good effect.

A case of chorea of very unusual severity markedly and rapidly improved by the use of *strychnine* after *all* the usual and unusual remedies had been tried in vain. We will yet learn *why* these things are so. At present we are necessitated to be empiricists in much of our treatment, but the thoughtful, observing, practical physician learns more every day what is essential and what not, and in using his knowledge does aid in curing disease.

—Dr. F. M. Hamlin, a prominent physician of Auburn, N. Y., was removed to an asylum at Utica, on March 23, as a victim to the morphine and cocaine habit. He was an expert microscopist, and a year ago was commissioned by the British Government to go to the Bermudas and investigate the causes of the onion blight. He made an elaborate report. For several years he has made a study of the morphine habit and has made a specialty of treating patients addicted to it, and notwithstanding this fact has succumbed to the habit himself.

ELECTROLYSIS *VERSUS* OÖPHORECTOMY.

BY WILLIAM R. D. BLACKWOOD, M.D.,
PHILADELPHIA, PA.

For some years past I have intended suggesting the use of strong currents of electricity with a view to destroy the functional activity of the ovaries, but other matters have occupied my time and prevented my doing so. The communication of Dr. Kimball, in the REPORTER for March 3, has renewed my desire to offer the experience resulting from four cases in which ovulation has, I believe, been thus destroyed. The relation of menstruation to ovulation has not been settled yet, nor has it been demonstrated that the menopause depends upon the ceasing of menstruation or ovulation alone. Surgical removal of the ovaries and the tubes does not invariably prevent the monthly flow, although it usually does so. I have seen well-defined menstruation occur in women who have undergone ovariotomy, and Tait's operation singly or combined, and although the flow was neither free nor regular it was considered by the women as menstruation, and to me it was such. I do not believe that electrolysis would be advisable in many cases, nor would it supplant the furor for doing abdominal section, which so many young men (and women) feel that predestination has forced upon them. Electricity makes no fuss, leaves no puckered scars, sheds no blood, and can't exhibit the "specimens" to the gaping public in the doctor's sanctum, but I believe that in selected cases it will annihilate functional activity in these pestiferous organs which have mysteriously bothered women for a few years past. Let me illustrate.

In the last twenty years I have treated with localized electricity in its three forms a little over eleven hundred cases of ovarian neuralgia, or of general nervous disturbance believed to be dependent on ovarian congestion or inflammation, with or without associated uterine disease. Although I sometimes employed Faradism and static electricity, the great majority were treated by galvanism, and rarely with currents of more than fifty milliamperes. In some as much as two hundred milliamperes were used, and a profound impression of course resulted. I reported a few of my earlier cases, but as professional attention was not directed to electrolysis at the time, I ceased doing so. At a meeting of the Philadelphia County Medical Society ten or twelve years ago, the late eminent gynæcologist Dr. Albert H. Smith, condemned my use of from one hundred to two hundred milliamperes intra-uterine, and he was supported by others in his remarks, who, from all I can learn, never owned anything beyond a cheap Faradic machine either then or now. The three cases reported then as cured of membranous dysmenorrhœa and menorrhagia were (unknown to him) women who were unrelieved by his services, yet they remain cured to-day by my unwarrantable and inexpensive treatment. Apostoli wasn't around then.

1. In a case of extra-uterine pregnancy treated by high Faradic tension,[1] together with galvanism, the patient had given birth previously to three children, but since the electrolysis ovulation is apparently suspended or abolished; I believe it is destroyed. From a previous menorrhagic habit she is now scanty in her flow, and she wants fifteen years, at least, before the menopause is due. I sent a current of three hundred milliamperes through her ovaries twice for ten minutes, and a Faradic secondary of 7″–12″, first on one side and then on the other, for an hour, several times. The current traverses the uterus, the tubes, and the ovaries, in all applications. A complication which for nearly three years thereafter worried her and myself, was peristent chronic diarrhœa due, I feared, to paralysis of the intestinal muscular fibre from diffused currents. It was impossible to prevent this side-escape, or to isolate the pelvic nerve-trunks, hence I supposed the diarrhœa due to molecular destruction of portions of either tissue. Now I know better—it was masked intermittent, and was cured by arsenic and opium in very small doses, after failure of every known astringent or remedy against diarrhœa, suggested by professional friends.

2. Another case was that of a woman with chronic ovarian congestion, and in her I used Faradism to her utmost ability to stand it. The rheophores were applied, one over the glands singly, and the other in the uterus. After half a dozen seances her malady quit, and her health returned. She is only twenty-two, but she has ceased menstruating for two years. Her general health is exhuberantly perfect.

3. Again, another ovaralgia case, treated by galvanism and Faradism. Six weeks of moderate electric treatment was negative, and as she was a personal friend, as well as my patient, I was desirous of curing her; hence, I increased the doses to the utmost capacity bearable without anæsthesia. A few applications relieved her for a year, and on a threatened return I gave her a single

[1] *Medical Bulletin*, May, 1885.

dose of two hundred and seventy-five milliamperes, followed next day by Faradism up to 12″. She dropped her ovaralgia, and her ovulation also, I think. At any rate, she used to suffer for three or four days after menstruation ceased from pain, which stopped when accompanied by a little hæmorrhœa lasting only an hour. Her periods now are also scanty, short and painless; she has no secondary discharge. I believe ovulation occurred under the last flow, (that lasting an hour or so), and she is now sterile, or has been for several years. She was productive before the electrolysis.

4. The last case referred to is that of a woman presumably suffering from incipient cystic ovarian disease. Tumor was hereditary in her family, and she dreaded ovariotomy. I used strong electrolysis twice weekly for three months, and the swelling disappeared. So did ovulation, I am sure, although she menstruates regularly but scantily, when compared with her usual manner prior to the feared cystic development. She conceived and aborted three or four times a year before the electrical treatment—now she is barren, for there is no lack of trying to be a mother and her husband is all right.

If electrolysis did not destroy ovarian function in these cases, how can the subsequent history of apparent sterility be explained? That weaker currents than such as were used by me in the cases instanced will disorganize ovarian tissue, in recent specimens I know from abundant experiment. Why, therefore, should not very powerful currents do so in the living subject? Improper electrical treatment has utterly ruined many cases of paralysis, both infantile and in the adult, as every neurologist can testify; and electrolysis long continued will destroy the function of both nerve and muscle—why won't it do so in ovarian stroma?

The only question as I see it is the selection of cases, the method of application, and the attention due to the safety of the woman. I don't like a big abdominal poultice for the positive even if it is Apostoli*cal*. I prefer a well localized cataphoric rheophore not over two inches in diameter. It won't produce sloughs with care under galvanism, and Faradism won't do harm anyhow. There is more skill required in applying the vaginal rheophore, which must have a bare ball or disk. We can alter its position considerably from time to time, yet reach the ovary. I mean to try electrolysis for the purpose indicated hereafter, and I shall report the result. If electro-therapeutists will also experiment a little, something may come of it.

ON THE IMPORTANCE OF PRIMARY SUTURE OF DIVIDED NERVES, WITH AN ILLUSTRATIVE CASE OF SUCCESSFUL SUTURE OF THE MEDIAN AND ULNAR NERVE.[1]

BY CHARLES B. NANCREDE, M.D.,

SURGEON TO THE JEFFRESON MEDICAL COLLEGE HOSPITAL AND TO THE EPISCOPAL HOSPITAL, PHILADELPHIA.

Although I have a most profound faith in the vis medicatrix naturæ, I still think that Dame Nature should always have fair play in her battle with injury or disease, and this she certainly fails to receive at the hands of too many practitioners. In a paper published some fifteen years ago, I contended that, if with such vascular structures as those of the face, which certainly would unite sooner or later in some sort of fashion, we habitually resorted to suture, merely for cosmetic effects, we were all the more bound to do so for such vascular structures as tendons, which, if they failed to heal well, much more if no union was secured, must entail disability or total uselessness of a member. Nowadays a surgeon who should fail to suture a divided tendon would be considered derelict in his duties. In like manner, I trust, that in the near future the general practitioner will be so impressed with its importance that he will consider that his duty is unfulfilled until he, or some surgeon summoned by him, has sutured any divided nerve. It is needless for me to dilate upon the evils consequent upon the abolition of function of an important nerve, but I would recall to your minds cases which must have occurred in the practice of most of those present, where divisions of even such small trunks as digital nerves have resulted in troublesome ulcerations, causalgias, etc.

Doubtless the indifference of practitioners to wounds of nerves, or, more strictly speaking, their inclination to "leave them to Nature," has arisen from two causes, viz., (1) the fear that suturing might in some way determine tetanus, and (2) the well-known fact that nerves divided or even excised with the avowed intention of abrogating their function, too commonly reunite. The first cause should not deter us, as we now know that a suture, *per se*, can never originate tetanus; while as to the second objection, certain facts which I shall submit for your consideration warrant the conclusion that traumatic divisions of nerves, unless effected

[1] Read at the meeting of the Philadelphia County Medical Society, March 14, 1888.

by a clean cut—or perhaps ball wounds—involving solely the nerve and little, if any, of the contiguous structure, differ so materially from those purposely effected by the surgeon's knife, that conclusions derived from the result of neurectomies cannot safely be applied to accidental divisions of nerves. Besides, granting that reunion will occur without suturing, as a stitch can do no harm, why not use one, since it will at least conduce to a more rapid resumption of function? While primary union of nerves with immediate resumption of function—*i. e.*, in a week or ten days, is a surgical rarity, yet it does at times occur, and would doubtless be of more frequent occurrence, if suture were the rule and not the exception.

My aim in this brief note is merely to call your attention, as general practitioners in whose hands many of these cases will fall, to the *duty* of suturing divided nerves as a routine practice, just as you would tie arteries, and to describe a simple, effective method of carrying out the indication. A critical examination of the histories of nearly all exsections of nerves where reproduction has occurred, will show that they were removed either from a bony canal or from an intermuscular space in which they normally laid, *with the minimum* of injury to the surrounding tissues. Moreover, even when their ends have been turned back and sutured in position, or even buried in the surrounding tissues, they have been so secured in the same intermuscular space which the nerve normally traverses. In other words, the bony canals and the intermuscular spaces likewise, act as moulds which direct the course of the reparative material from the proximal to the distal end of the severed nerve. In extensive wounds, however, this condition does not obtain. Intermuscular spaces are dislocated, large masses of scar tissue are formed, so that instead of the new nerve-tissue being *compelled* to grow in only one, and that the right direction, it has too often an insuperable barrier interposed, and union fails.

In the case which I now show you,[1] the proximal ends of the ulnar and median nerves were directed at right angles to their intermuscular space, and would have been infallibly fixed between the ends of the torn muscles in a dense mass of scar tissues, resulting in permanent loss of power of the member. In the seventh month after suture, *i. e.*, the usual period required for the degeneration and regeneration of a nerve, first sensation, and then motion returned, until now, although the functions of the member are not perfect, the boy can earn his living, and do nearly all that can be effected by a normal hand and forearm.

Further quotation of my own cases or those of other surgeons seems hardly necessary, and such good results as I here show you have been frequently reported.

Finally, how should the sutures be passed and what should their material be?

Fine aseptic catgut passed by means of an ordinary sewing needle is to be preferred, but fine aseptic silk can be used, and I myself have resorted to this in an emergency. Should the nerve be *very* much lacerated and frayed out, it may, perhaps, be sometimes proper to cut off a portion to gain a clean surface, but this is rarely desirable. The needle should be passed from below upward through the proximal end of the nerve at one border, across and then passed from above downward near the opposite border, entering the needle from an eighth to a quarter of an inch from the cut end, according to the size of the nerve. The needle must now be passed from below upward through the distal portion of the nerve at the border corresponding to the last passage of the needle through the proximal end, across, and made to pierce the nerve from above downward, when the suture will be found to correspond to the free end of the thread in the proximal piece of nerve.

Gentle traction with an appropriate position of the member will, by the tying of one knot, accurately approximate the nerve ends. In a word, by this simple method all the advantages of the two separate sutures commonly recommended are obtained with a far greater degree of security. I need not say that the strictest asepsis should be secured, which is easy enough, provided the wounded part, the surgeon's hands, and his instruments be strictly cleansed, and the wound be freely irrigated with the bichloride and tartaric acid solution. If the surgeon gets an uncontaminated wound, it is his own fault if he has suppuration, and even with the ordinary run of accidental wounds, if he will thoroughly scrub his hands with a nail-brush and hot water, and likewise so treat the parts surrounding the the wound, pour boiling water over his instruments, without any fur-

[1] In this patient the brachial artery was also torn through, leaving only a bridge of muscle and skin through which collateral circulation could be carried on. The deficient blood supply possibly explains the failure of the recovery of power in the interossei muscles, although other of the intrinsic muscles of the hand which are supplied by the ulnar nerve contract well.

ther antisepsis, in most cases healing without suppuration can be secured, while the omission of these details will mar results with gallons of mercuric solution flowing over the wound.

JABORANDI IN OBSTETRIC PRACTICE.

BY JEROME HARDCASTLE, M.D.,
CECILTON, MD.

Having for many years noted the fact that parturition does not progress favorably till *diaphoresis* occurs, I have for some months past induced this condition, in the early stage of labor by giving fl. ext. jaborandi (*green*—the brown has proved worthless in my hands). My plan is, when called to a case, to order a warm brick to be applied to the feet—which are always cold, and then to give one-third of a teaspoonful of fl. ext. jaborandi in half a wineglassful of water, and repeat the dose every half-hour until perspiration occurs. It is very seldom that more than two doses are required. The first effect of this medicine on the patient is soothing, she becomes more quiet, and bears her pains with resignation. Upon being questioned the patient often states that her pains do not hurt her as they did. On examination, after diaphoresis occurs, the os will be found dilating rapidly; the soft parts to be in a favorable condition; and in a short time the labor will be satisfactorily terminated. Should the patient appear weak from the sweating, I wipe her face and neck with a dry towel, and give her a teaspoonful of whiskey or half as much of aromatic spirits of ammonia.

Since using the above remedy, I have had no occasion to use ether, chloroform, or the forceps. I have not seen any mention of the use of jaborandi in obstetric practice; but, having had such favorable results from its employment I recommend it to the consideration of the profession.

—The *Engineering and Building Record* of March 3, 1888, says: The Directors of the Great Northern Railway have recently issued an order to their firemen and engine-drivers which should be the imitation of similar regulations throughout the various railways in the country. No fireman or engine-driver is to be allowed to go on duty unless he has had at least nine hours' rest. Such an instruction should not be necessary, but being necessary, its issuance is no less a boon to the men than a source of safety to the public.

SOCIETY REPORTS.

COLLEGE OF PHYSICIANS OF PHILADELPHIA.

Stated Meeting, March 7, 1888.

The PRESIDENT, S. WEIR MITCHELL, M.D., in the chair.

In opening the discussion on Dr. Ashhurst's paper[1] DR. WILLIAM HUNT said: Dr. Ashhurst has dwelt upon the importance of saving time. There is one way in which time might be saved, and that is by more than one surgeon operating at the same time. Dr. Morton and I have done that on two occasions, each taking a limb and operating at the same time. I do not know how it would work with three.

DR. H. C. WOOD said: I should like to make a remark with reference to this point of keeping up the animal heat. Many people die in acute disease, in acute poisoning, and after severe operations, because the temperature is not maintained. I have proven by experiment that if two animals are subjected to severe injury, and one is kept in a moderately cool room, and the other in a hot room, the one will die and the other recover. In this connection I will repeat a suggestion made to me by Dr. Dercum, which would afford one of the most efficient measures for maintaining temperature—and that is, to fill the ordinary water-bed with hot water, and allow the patient to lie on it.

DR. CARR, of Washington, said: I did not know until I heard the remarks of Dr. Ashhurst the importance of a case that I have had. I have performed a quadruple amputation for frost-bite. The patient was brought into the hospital in a condition of collapse with the four extremities frozen. He reacted well, and remained in the hospital a week, when his constitutional condition became serious, and after consultation it was decided that amputation of the four extremities was desirable. I operated, removing one foot above the ankle, the other foot through the metatarsal joint, one forearm about its middle, and one hand, leaving a small stump of the thumb, disarticulating it at the metacarpophalangeal articulation. The patient did very well.

In operating I secured the vessels with hæmostatic forceps, and left the stump in that condition while I proceeded to amputate another limb.

[1] See page 423.

DR. J. WILLIAM WHITE said: I understood from Dr. Ashhurst's paper that in his classification of triple amputations partial amputations were not included. I had last year at the University Hospital a double knee-joint amputation, with amputation of a portion of one hand, leaving a thumb and one finger, and should have been glad to present the patient this evening.

In reference to the technique, I have only one or two suggestions to make. If the irrigation is done with warm or hot water, it does not necessarily reduce the temperature, and, in fact, may aid in keeping up the bodily heat. The same is true with reference to the use of wet towels, which can be rung out of hot water and frequently renewed. Bramann, assistant to von Bergmann, has recently detailed the results obtained at the latter's clinic by packing wounds with iodoform gauze. This prevents the formation of a blood-clot, which is, perhaps, next to a failure to secure asepsis, the most important cause of the failure to obtain primary union. Where there is danger of oozing, he packs the wound with iodoform gauze, which is allowed to remain from forty-eight to seventy-two hours. It is then removed and the sutures applied; in the vast majority of cases union by first intention is secured. Even when it was left *in situ* for from four to six days such union occurred after suturing. In a case of double or triple amputation time might be saved by packing the first operative wound with iodoform gauze as soon as the vessels are secured, and then dressing it. This could be done by an assistant, and the patient removed to the ward much sooner than if time were taken to introduce stitches. The suturing could be done any time during the next two or three days.

DR. MITCHELL said: I have listened with a great deal of pleasure to the remarks as to temperature of patients under ether or chloroform, and the possible influence of irrigation upon these cases.

I would like to ask what some of the gynecological operators would say. In their cases the abdomen is sometimes largely opened, and the intestines exposed; if irrigation lowers the temperature in ordinary surgical cases, how much more should it do so in these?

I think it would be advisable to have a series of experiments and observations as to the effects of ether, chloroform, and perhaps other anæsthetics, upon the temperature, when used for long periods. As concerns the interesting case of triple amputation shown us by Prof. Ashhurst, I would like to say that no physiological statement has been made, so far as I know, as to the effect of large losses of tissue upon the pulse, temperature, nutrition, blood-pressure, amount of urine, etc. A tempting subject here awaits some industrious observer.

DR. WHITE said: Experiments are now being made at the University of Pennsylvania, upon animals and clinical subjects, to determine the effect of the administration of ether on the bodily temperature, and seem clearly to indicate that a drop of from one to three degrees may be expected, not only in cases where no irrigation was used, but even where no operation of any sort has been performed.

The note of a case has just been handed to me, in which the temperature fell four degrees. The temperature before operation was 99.5°, and after operation (which was the removal of a tubercular testicle) it was 95.5°. No irrigation was employed. No general symptoms of shock, such as weakness or failure of the pulse, leakage of the skin, or shallowness of respiration, were observed in this case. A series of nine cases of all sorts of operations gave similar results, though the average reduction of temperature was not more than two or three degrees.

DR. WILLIAM GOODELL said: In removing the ovaries, one has to be very cautious on account of the collapse that may occur if the ovary is pinched or roughly handled. Something similar, I fancy, would occur in the removal of the testicle, and this, I think, had a good deal to do with the fall of the temperature noted.

DR. ASHHURST said: The suggestion made by Dr. Hunt is an old one. Before the days of anæsthesia it was thought that the patient might suffer less pain by having both operations done at once; but when the patient is insensible, there will certainly be less confusion by having only one done at a time.

With reference to irrigation, as I have already mentioned, I have seen the temperafall as low as 97° after a simple operation, and in operations not usually considered capital, such as the removal of the breast, the temperature has gone even lower, and the patient has remained in an extremely critical condition for hours. This has been where there has been no loss of blood, and no condition other than the irrigation to account for it. In cases where antiseptic measures have not been employed, I have not seen this depression, except when there has been great loss of blood, or unnecessary exposure of the patient.

In my list I have not included any but synchronous major operations. The cases

reported to-night seem to have been instances of minor amputation, as regards some of the parts removed, and can, therefore, technically be looked upon as only double, not triple, or quadruple amputations.

Another word with reference to irrigation; even if warm solutions be employed, they will tend to cool the body by evaporation, and the same is true with regard to wet towels; even if hot when applied, they will reduce the temperature unless covered with oiled silk to prevent evaporation. I do not think that the administration of ether alone has much effect upon the temperature, but under any circumstances we can better dispense with irrigation and wet towels than with anæsthetics.

In regard to the case of excision of the testis, which has been mentioned, it may be said that operations on the testicle necessarily require considerable exposure of the lower part of the abdomen. It is also a well-known fact, that division of the chord is often followed by profound shock. This observation has been made by Mr. Erichsen, at the University College Hospital, London, and my own experience confirms it. The moment that the chord is divided, the pulse fails decidedly, and there is more shock from removal of the testicle than from any other operation of equal gravity in the whole range of surgery.

I have no objections to the antiseptic method of treatment, and I am in the habit of employing it, but I think that we should not close our eyes to the fact that it may have some disadvantages. I think that the maintenance of the patient's temperature is of more importance than the exclusion of a few microbes. All that can be accomplished by irrigation can be equally accomplished by washing the part before and after the operation, care being taken to keep the patient warm and dry. The ordinary antiseptic dressings were employed in this case after the operations; I consider that their chief advantage is that they permit infrequent dressing of the wound.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, March 15, 1888.

The President, A. Jacobi, M.D., in the chair.

Dr. F. R. Sturgis read a paper

On Some Questions in Connection with Syphilis Hereditaria Tarda.

It was only within the past twenty-five years, he said, that many diseased conditions had been ascribed to their true cause, namely, hereditary syphilis. The question which he wished to discuss was whether hereditary syphilis might lie dormant in the system, and first declare itself several years after birth. It was pretty generally acknowledged at the present day that if a patient presented himself to the surgeon with the advanced lesions of syphilis that the patient had had other and milder manifestations of the disease at some prior time. Surgeons went further and stated that the disease must have begun with an initial lesion, although no traces of it could be discovered.

Tables were given to show that in the majority of cases hereditary syphilis showed itself before the third month of life; but it was said that there were cases in which symptoms did not become manifest until later, and then the question arose, how much later?

Here Dr. Sturgis gave a brief account of cases reported by different observers who had asserted the occurrence of the first symptoms of hereditary syphilis at the twelfth to the twenty-seventh month, and in three cases from the twelfth to the fifteenth year. Comparing the histories of these cases with that of the usual history of hereditary syphilis, it would be seen that there was liability to mistake acquired syphilis for the hereditary form, and to overlook earlier symptoms of the latter disease. In the three cases quoted in which the symptoms of syphilis appeared at or after the twelfth year, Dr. Sturgis thought acquired syphilis could not be excluded. In the other cases early symptoms may have been mild, and therefore may have been overlooked. It was his own opinion that late symptoms of the hereditary form were always preceded by early symptoms, although the physician might be unable to draw out a history of the latter from the patient's relatives and friends. Sometimes it left the remains of an old keratitis, of mucous patches, etc.

Dr. E. L. Keyes thought late symptoms of hereditary syphilis were always preceded by early ones which had been overlooked or forgotten. Incidentally in the discussion he expressed the view that syphilis was a much more serious disease in children than in old people, because of the difference in soil; also that bichloride of mercury should be administered to young infants who had hereditary syphilis, say in one-fiftieth of a grain doses every two hours at first, and, as the symptoms began to yield, at longer intervals.

Dr. P. A. Morrow would be very much inclined to doubt whether any patient manifesting late evidences of hereditary syphilis had entirely escaped the early symptoms. He

had seen cases in which he had been unable to trace the history of early symptoms; but he did not regard that fact as at all conclusive that the early symptoms had not existed.

There was a disposition, he thought, to underrate the liability to lesions of hereditary syphilis after adolescence. We know patients might manifest acquired syphilis five or fifty years after taking it, yet hereditary syphilis was essentially the same disease.

Dr. R. W. Taylor said that while he looked upon hereditary syphilis as more erratic than the acquired variety, yet he was a firm believer that in the hereditary form there was always some manifestation in early infancy. If it could not be traced, it was because there were no remains of old lesions, want of persistence on the part of the surgeon in bringing out the history, or the ignorance of the patient and his friends.

Regarding lesions of hereditary syphilis after adolescence, he did not doubt but what they might occur, but he still claimed, as he had done in his chapter on this subject in Bumstead and Taylor's book, that after the twenty-first year it was extremely difficult to definitely exclude acquired syphilis, and unless strict precautions were enforced, physicians would be likely to attribute lesions to hereditary syphilis in many cases in which hereditary syphilis was not at all at fault.

Regarding the syphilis of old people being a light affair, as claimed by his friend Dr. Keyes, the statement was to him astonishing; for he had found that if there was ever a scourge to old people, it was syphilis.

Drs. L. B. Bangs, H. D. Chapin, A. S. Hunter, L. E. Holt, Goodwillie, and the President participated in the discussion. The general view was that late lesions of syphilis had been preceded by early ones, although the history might not be traceable.

SECTION IN PRACTICE.

Stated Meeting, March 20, 1888.

R. C. M. Page, M.D., Chairman.

Dr. J. West Roosevelt read a paper on **Pernicious Anæmia: Certain Questions Suggested by Cases and Autopsies.**

From the study of certain cases of pernicious anæmia which had come under his observation and of reported cases he had been led to the following conclusions: (1) That in some cases of pernicious anæmia there is found a lesion of some important organs which, in certain cases, may have produced the blood disease. (2) That after these cases, together with those which seem to be caused by parasites and those which follow hemorrhage have been excluded, there remain some in which the blood lesion seems to be primary.

The first case related was that of a girl 20 years old, who had indulged in a peculiar and bad diet, and had taken much tea. She was at the age when simple anæmia is common. For a year she had menstruated irregularly, but she dated the real beginning of her illness from the period at which menstruation ceased, four months before admission to the hospital. Two months before admission she observed that she was paler than before, and she had occasional œdema of the feet. She did not seem to have been ill, however, until after an attack of jaundice one month before Dr. Roosevelt saw her. Following this and two similar attacks the graver symptoms appeared. Although she had temporary improvements she finally died, having presented the usual symptoms of pernicious anæmia. Dr. Roosevelt thought it might be assumed from the autopsy that the jaundice was the result of inflammation of the bile ducts produced by calculi found in the gall bladder. According to the patient's own statement the disease terminated fatally about eight months after its onset. As menstruation had been irregular for a year it was probable she had suffered from anæmia at least that long before admission. Taking into account the patient's age and her diet he thought it possible that the disorder began as a simple anæmia, and that the attack of jaundice still further increased the anæmia. As a result of the jaundice the blood-forming organs were taxed beyond their powers. Jaundice had been noted in several cases of pernicious anæmia.

The second case gave a very different history. There had been chronic gastritis extending over six months at least. Emaciation was a prominent symptom. The only apparent reason for the anæmia, besides the stomach lesion, was the occurrence of severe bleeding from piles thirteen years before the patient's admission. In spite of the emaciation the case resembled very closely pernicious anæmia. The autopsy showed the lesions of chronic gastritis. There was a question whether chronic diffuse nephritis was present, but the author was disposed to think the kidney changes were those of natural increase of fibrous tissue found usually in patients of her age. Of the relations between the stomach lesion and the symptoms this much alone could be said, that many patients lived a good while and pretty com-

fortably with a stomach as bad as this one. When this patient became very ill she presented symptoms like those produced by malignant disease. These symptoms were rationally explained by the blood state. It is possible that the blood state was secondary to the stomach lesion, but we would have to admit, for the production of pernicious anæmia as the result of gastritis, the necessity either of independent disease of the blood forming organs, or that as the result of the stomach lesion such a change took place in the gastric ferments as to lead to the production of poisonous digestive products instead of normal peptones. Evidence that the stomach and blood lesion were both the result of the same cause is wanting. It is interesting to note that in a number of reported cases symptoms of dyspepsia had preceded the anæmia.

In a third case of which the author gave a detailed history there was a condition of pernicious anæmia complicating Bright's disease. The patient died thirty-one days from the commencement of his blood lesions and hemorrhages from the rectum and mouth. Of course, said the author, the occurrence of symptoms of pernicious anæmia during the course of Bright's disease is well known. The blood had not yet been sufficiently often examined, but the patients seem to suffer from the same symptoms as those of pernicious anæmia, and in this case the blood lesions were typical.

Dr. Roosevelt gave a brief general description of pernicious anæmia. The onset was usually gradual. Pallor was frequently the first symptom noted, and when the disease had become fairly developed it was frequently rather characteristic; the skin had a yellow, lustreless, white tint. Dyspnœa, cardiac palpitation, headache and symptoms of increasing weakness developed; sooner or later an irregular fever set in; there might be some dropsy; patients usually retained their fat, or it might increase; hemorrhage from various mucous membranes occurred in some cases; hemorrhage into the retina and chorid was almost invariably present. The red blood discs and hæmoglobin were below the normal; the reduction might reach one-sixth or one-seventh the normal. The white blood cells were nearly normal in number. The red cells showed changes in size and shape, and it was said nucleated discs sometimes appeared.

In some cases death took place in a few weeks or months; in others, not for years. Temporary improvement followed by relapses was often seen. The diagnosis from simple anæmia was difficult, and sometimes perhaps impossible. There seemed to be no symptom nor group of symptoms found in the grave disease which were not found in the milder type. Of course, if by pernicious anæmia we meant necessarily fatal anæmia, we might wait until death or recovery cleared up the diagnosis. The resemblance of these cases to Addison's disease was quite marked, but in the latter disorder anæmia was not a necessary symptom. Whether or not it was closely related to Hodgkins' disease and to leucocythæmia is not yet quite settled. Clinically, Hodgkins' disease is differentiated by the lymphatic, splenic, or hepatic enlargements, while the excess of white cells distinguishes leucocythæmia from the others. As to lesions, the blood during life is paler and thinner than normal. The red discs are much diminished in number, perhaps fifteen or twenty per cent. of the usual number could be found. The discs are more or less altered in size and shape; the white cells relatively, but probably not absolutely, increased in number. In other organs the most common lesions seem to be fatty degeneration of the heart, liver and kidneys; similar degeneration of the great vessels had been found. Hemorrhagic extravasation into the retina and chorid is almost constantly found. Together with some optic neuro-retinitis, extravasations of blood elsewhere may occur. Inflammatory changes in any of the organs may occur as an incident of the disease. The serous cavities often contain an excess of blood. Gastric lesions, chronic diffuse nephritis, lesions of the pancreas, fatty changes in the liver, etc., have been described. Intestinal parasites are sometimes seen. The body is usually fat; the muscles and all the organs pale; the fat is often of a peculiar yellow.

The etiology is not clear. If overwork, bad food, foul air, pregnancy, gastritis, etc., etc., are, as has been suggested, causes of pernicious anæmia, the disorder should be very common instead of very rare.

Looking at pernicious anæmia as he had defined it, making the definition broader than many would admit, might we not say, he concludes:

1. That a condition with similar course and symptoms had been observed in cases with precedent grave stomach, kidney and liver lesions?

2. That in these cases, however, the condition was so rare as to make it difficult to suppose that under ordinary conditions the blood state could be the direct result of them?

3. That in all cases in which there had

been any other tangible cause this had hardly been sufficient of itself to produce the disorder? There was too much gastritis, Bright's disease and misery seen without such effect. The same was true of every other cause.

4. Let there be congenital or acquired weakness of blood forming organs and then, as various authors had suggested, it would be conceivable that by a "vicious circle" the condition might result.

5. That after all known possible causes had been excluded certain cases still remained.

Finally, he would direct attention to the fact that in many cases, whatever be the supposed cause, there was a history of long-continued gastro-intestinal disturbance before the onset of the pernicious symptoms. In view of this, was it not possible that some of the cases were the result of poisoning by substances produced in the gastro-intestinal tract? If there was such a possibility, should not efforts be directed toward clearing out this tract in all primary cases?

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, March 14, 1888.

THE VICE-PRESIDENT, W. W. KEEN, M.D., in the Chair.

In opening the discussion on Dr. Nancrede's paper, on the

Importance of Primary Suture of Divided Nerves, with an Illustrative Case of Suture of the Median and Ulnar Nerve,[1]

DR. H. R. WHARTON said: I have seen one or two cases of primary nerve-suture, though none in which the injuries were so extensive as in this interesting case of Dr. Nancrede's. The results in these cases were good. There is another point to be considered. Shall we attempt secondary suture of the nerves when this has been omitted in the first place? I am very decidedly of the opinion that this procedure should be adopted, for a number of cases have been reported of this character, in which the results have been at least good suture enough to make me feel that secondary should be attempted when there is any probability of restoration of the use of the injured part. I thoroughly agree with Dr. Nancrede as to the great importance of this subject.

DR. JOHN B. ROBERTS: The only case of nerve-suture I remember at present is one in my wards, in which the work had very properly been done by the resident immediately on the admission of the patient. It was a rather extensive incised wound of the leg, involving, I think, the musculo-cutaneous and anterior tibial nerves. The muscles and nerves were sutured and dressed antiseptically, and the results were good; though I did not follow the case after discharge so as to make an accurate report as to sensation. Dr. Nancrede has incidentally touched upon a point of great importance, that of teno-suture. It has been my misfortune to meet with quite a number of cases in which this had been neglected by the attendant called at the time of the accident. One of these recently seen was that of a man wounded in the forearm just above the wrist, and in the ring finger. There was loss of flexion of the finger, but it was hard to tell which of the wounds to reopen in order to come upon and suture the divided tendon. The family physician believed it to be the wrist; but after cutting down, I found the tendon here flaccid and intact. I then opened the finger-wound, and here found the tendon retracted into the sheath. I sutured, but did not get a good result, probably from the extent of dissection necessary to get at the tendon in the sheath, and the great mass of cicatricial tissue. However, I never hesitate to reopen healed or partially healed wounds to suture tendons when this very important measure has been neglected.

I have been glad to hear Dr. Nancrede say that with cleanliness of person and of instruments asepsis can be secured without chemical solutions. This is in marked contrast to one of my friends, a surgeon of prominence, who thinks that the employment of solutions renders care as to cleanliness unnecessary.

DR. J. WILLIAM WHITE: I do not know whether Dr. Nancrede spoke of the resection of the crushed and bruised ends of the nerves or not. The general principles of nerve-suture are admitted by all surgeons, but the question of resecting lacerated or contused ends before suturing, or of allowing them to remain, is one that should be carefully considered in each case. On the one hand, by resection of any considerable portion we increase longitudinal tension, and make greater strain on the sutures; on the other, we run the risk of including in the stitches tissue too much damaged to recover itself. There is some difference of opinion as to the particular suture to be employed. I should think that the one proposed by Dr. Nancrede, as shown in his diagram, would be open to objection, if, as there apparently repre-

[1] See page 429.

sented, it interposes a foreign substances, the catgut thread, between the ends of the nerve; this, if not absorbed, as is sometimes the case even with the best catgut, is liable to be a constant source of irritation, and to prevent union. I prefer and employ a suture passing quite through the nerve above and below the point of union. Evidence, either clinical, or pathological, or experimental, as to the relative advantages of different sutures is desirable, but I do not know of any, and I did not understand Dr. Nancrede to say that there was such evidence.

The CHAIRMAN, DR. W. W. KEEN: There are two case I may briefly cite from my own experience in connection with the subject of our discussion:

1. A case of primary nerve-suture in a boy two years of age, with perfect recovery of motion and sensation. The case occurred ten years ago. The child, carrying a glass bottle, fell, and a fragment of glass divided the ulnar nerve and artery about an inch and a half above the wrist. The mother made compression with her thumb until I arrived, very soon after the accident. After ligaturing the artery, I examined the nerve and found that it had been divided. I had only my pocket-case containing coarse white silk and an ordinary needle. Not wishing to leave the coarse silk in the wound, particularly not in the nerve tissues, I debated as to the method of suture, and devised one which proved eminently satisfactory. Drawing the ends together closely with forceps, I passed a surgical pin obliquely through the two divisions, threw a loop of silk around the point of the pin (as in Simpson's method of acupressure), drew out the thread, passed it around the head of the pin, where it was secured. At the end of forty-eight hours the pin was removed. The thread was thus loosened and removed. Perfect union of the wound took place in a few days. There was no wasting of muscles, and motion was present after twenty-four hours. While the age of the child prevented exact observation as to the time at which sensation returned, at the end of forty-eight hours there was an exclamation of pain on pricking the little finger with a pin. I saw the father of the boy about a year ago, who told me that his son had perfect use of hand and fingers.

2. Extensive teno-suture, with quick union. A recent case shows the value of even a brief suture of tendons. A man twenty-five years of age was admitted into St. Mary's Hospital with complete severance of all the tendons of the forearm and of the sheath above the wrist. The resident sewed each tendon carefully. He had only Kocher catgut, which does not remain more than three to five days, and then closed the external wound and placed the hand in flexion on a splint. The man left without permission after a few days, and it seems removed the splint and tore out the sutures in the skin. He returned later with a gaping wound in the forearm, but on testing the fingers separately each finger and each joint was found to have perfect motion, showing that even this temporary apposition of the divided tendons had a perfect result. I should prefer for the purpose, however, either very fine silk, or, better, the ordinary chromicized catgut.

DR. NANCREDE: Dr. White has misunderstood me. There is nothing between the divided ends of the nerve. If he will examine the rough model which I pass around he will see that the nerve is securely and accurately coaptated by the suture. I have no distinct recollection of resecting the injured ends in this case, in fact, I am nearly certain that I did not. In some cases I have said it *might* be desirable, but I am dubious about it. In two other cases that I recall at this moment, I remember that I did not make any attempt of the kind, but brought the ends together as best I could. Referring to the incidental discussion, I am glad to hear that so many of our members always suture tendons. I make it a rule to suture nerves and tendons in every case, and generally obtain fair results.

DR. HOWARD F. HANSELL presented a patient with

Ectopia Lentis.

Clarence P., aged ten. This colored boy presents several deformities: A peculiar shape of head, deviation of spine, anterior curve of each tibia, and is more or less undeveloped. I have asked him to present himself before the Society in order that those members who may be interested may have the opportunity to see a case of "ectopia lentis," congenital upward displacement of each lens. The margins of the clear lenses may be distinctly seen about the centre of each pupil. The right lens is dislocated upward. The left, upward and outward. Each eye is highly myopic—*i. e.*, as seen through the lens, and hypermetropic as seen under the lens. The temporal side of each nerve shows a large patch of atrophic choroid—post-staphyloma. There is no coloboma of the iris or choroid. With the right eye the boy can read large print only when held two and a half inches from the eye in an upward and outward position. The left eye is useless.

Reports of Clinics.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

SURGICAL CLINIC—PROF. ASHHURST.

Triple Amputation—Recovery.[1]

The first patient is a young man, a Moor, who is almost ready to be discharged from the wards. He has been the subject of a triple amputation, rendered necessary by injuries which he received in a railroad accident. His right forearm and right leg were hopelessly crushed, and the left leg was completely torn off an inch or two above the ankle. When brought here he was, of course, in a state of shock, but as soon as sufficient reaction had been secured to render it permissible, the operation was begun. The site of the first amputation was through the lower third of the right thigh, the second through the middle third of the left leg, and the third just below the wrist of the right side. All three stumps are now completely closed, and the patient's condition is excellent. In addition to the injuries of his extremities which required amputation, there was a compound fracture of the skull (the frontal bone), without, however, much depression. There were several severe contused wounds of the scalp, and a number of others distributed over the remaining portions of the body, some of which gave rise to deep and extensive sloughs. Recoveries after such severe injuries as we have had here, are very rare. Success, I believe, depends not so much upon the care and skill displayed by the surgeon in operating, as upon the constitutional vigor and healthy condition of the patient. I have had but one other case of triple amputation; and, although the man lived for ten days following the operation, he finally succumbed to exhaustion, due, unquestionably, to visceral disease resulting from alcoholic excesses. This young man doubtless owes his life to his youth and healthy condition, and to his temperate mode of life before his accident.

In cases like this, were there is grave injury, I invariably begin the use of carbonate of ammonium immediately upon the completion of the operation. Depending upon the age and condition of the patient, I order from two to five grains every two hours or oftener. This drug serves a double purpose—it not only is a powerful and prompt cardiac stimulant, but it acts, also, by maintaining the fluidity of the blood and so diminishing the tendency to the formation of heart clot. This is the condition present in the cases which received from the older surgeons the name of "secondary shock." It may cause death by gradual failure of the circulation, or it may kill suddenly by embolism. It may be necessary, of course, to combine with the ammonia such other stimulants as whiskey and digitalis, and the bodily temperature must be maintained by the application of hot-water bags, etc.

[1] See page 423.

Resection of Inferior Dental Nerve for Neuralgia.

This woman, past middle age, has suffered during the last four years from neuralgia of the lower jaw. In search of relief, she has had on different occasions, several teeth removed, but when the last one was extracted, her suffering, instead of being lessened, was aggravated.

We find that the pain follows the course of the inferior dental nerve. This, you are aware, is a branch of the inferior maxillary division of the fifth nerve. It enters the lower maxilla at the dental foramen, passes downwards and forwards in the dental canal beneath the teeth, emerges at the mental foramen, and distributes its terminal filaments to the chin and lower lip. Many different remedies and plans of treatment have been tried in the endeavor to afford relief to this patient, but all have proved futile. There can be no impropriety, therefore, in resorting to excision of a portion of the painful nerve.

Neurotomy, or simple division of a nerve, is not to be recommended, because prompt reunion would be almost certain to follow, and so render the operation useless. Resection, or neurectomy, is necessary, and a considerable portion of the length of the nerve should be removed, the object being to delay reunion as long as possible or prevent it altogether.

The nerve can be readily reached at its point of entrance to the canal. A semi-circular flap is raised from over the angle of the jaw, and the outer wall of the dental canal removed with a small trephine. The exposed nerve-trunk is now raised from its bed and about three-quarters of an inch of its length is removed. I will control the bleeding from the artery in the canal by introducing a plug of catgut.[1]

Gelatinous Arthritis—Excision of Knee-joint.

This patient is 45 years of age. His left knee began troubling him more than five months ago. The joint now, as you see, is

[1] The patient did well after the operation, the neuralgic pain being instantly relieved.

much swollen, the leg is somewhat flexed upon the thigh, and we find on palpation that the swelling has a doughy, semi-fluctuating feel. There is already some dislocation of the tibia; the ligaments are relaxed, and permit an abnormal degree of lateral motion. From the fact that motion of the joint is productive of severe pain, we are led to suspect the involvement in the disease of the layer of bone immediately beneath the articular cartilage.

I need scarcely tell you that this is an example of that variety of joint disease, called gelatinous arthritis. In this form the synovial membrane is found in a pulpy or gelatinous condition, which almost invariably leads to destructive disorganization of the joint. As the disease progresses, the articular cartilages undergo an analogous change, and it finally reaches the bones, which become softened and carious. The symptoms of this peculiar form of disease, appropriately called "gelatinous arthritis," and which is rarely seen except in the knee and elbow, differ from those of ordinary arthritis in several particulars. The swelling is more diffused, and attended with comparatively slight fluctuation, being of a doughy and somewhat elastic type. The pain is not very well marked, and in the early stages is of a dull character, differing both from the acute pain of ordinary synovitis and from the jumping pain which attends exposure of the bone by ulcerating cartilage. There is little or no heat, and should the part be at first red, the surface soon looses its color, often becoming at last positively blanched—an appearance so characteristic as almost to justify the name of *white swelling*, formerly given to these cases. Another diagnostic point is the mobility of the joint, which often remains even when the disease has reached an advanced stage. In the instance before us the morbid process has progressed so far that spontaneous cure cannot be hoped for, and removal of the joint becomes imperative. The question, therefore, lies between excison and amputation, and, in chosing between these two operations, preference should always be given to excision, provided that the circumstances of the particular case admit of a choice. In this case the circumstances opposed to this operation are the man's age and the extensive implication in the disease of the bones and surrounding tissues. Either extreme of life is considered unfavorable to excision on account of the long period requisite for recovery after the operation. If the soft tissues around a diseased bone or joint be extensively implicated, the result of an excision is less apt to be satisfactory than when this is not the case, though the operation is not absolutely contra-indicated by such a condition.

This patient has left the final decision of the operation to be performed to me, and I shall begin, therefore, as though I contemplated excision only; but if, on thorough exploration, I find that disorganization has progressed so far as to render the success of this operation doubtful, I shall resort to amputation. Excision of the knee-joint may be performed in several ways, but those of most common adoption are by the H, the U, and the simple transverse incision. The last is, in my judgment, the best, and is the one I shall select here. [After opening the joint cavity and subjecting it to a careful examination, the operator felt justified in attempting to save the limb by excising the diseased structures. The patient did well after the operation, the wound rapidly healing.]

Foreign Correspondence.

NEWS FROM PARIS.

Académie de Médecine.

A number of corresponding members now in Paris for the Congress of Surgery were at the last meeting of the Académie. M. Koegel, of Strasburg, read a note upon arthrectomy as practiced by him for gangrene of the knee. The process by which M. Koegel has obtained such good results consists in opening the joint, cleaning out the synovial cavity and the tendons or bones attacked by gangrene, and after applying appropriate remedies, making the limbs immovable for some time by means of a salicylate of soda cast. The disease should, however, be treated immediately on its appearance.

M. Queirel, of Marseilles, had employed antipyrine in hypodermic injections, and with women, as an anæsthetic, to diminish or overcome altogether the pains of labor. This remedy gave great success in these cases.

M. Doyen, of Rheims, made known the result of his researches as to the relation existing between the three microbes, those of puerperal fever, erysipelas, and purulent infection. He is inclined to think that the different manifestations produced by these microbes depend principally on their age and development. They undergo evolutions which make it difficult to decide whether they belong to a single or to several species. These observations, taken with those which M. Bouchard recently gave to the Académie, tend to confirm the

opinion that the idea which supposes the species of the microbes depend upon their form, is an error. The same microbe may be found under all the known forms. That is to say, in infectious diseases, these elements, though able to propagate infection and act as a means of carrying poison, are only the agents of the cause of disease, and not the cause itself. They may become the cause, but only in a secondary way, by carrying the disease from one subject to another.

French Congress of Surgeons.

The third congress of surgeons in France has opened. In his inaugural address, Professor Verneuil dwelt on all that surgery in France had accomplished up to date, and he drew a parallel between the attacks of Dr. Billroth, the German surgeon, and the praises bestowed on the efforts and results of French surgery in all the works of the learned societies in every part of the world. M. Verneuil thus spoke: "Dr. Billroth, after most violently attacking, with evident incompetence, our illustrious Pasteur, deliberately and without any reason reproaches French surgery for not keeping pace with the immense progress in surgical science made in Germany and England. I admit that we can, and that we should, learn something of our rivals, but I contend that it should be on a footing of reciprocity. I do not think we have far to go to find, in the esteem of our foreign friends, ample compensation for Dr. Billroth's attacks; in my opinion, no one is less capable than our eminent colleague of appreciating the value of French surgery, for the simple reason that no one is more ignorant of it than himself. If proofs in support of my statement were wanting, I would point out that I seek with you in vain, in the tenth edition of Dr. Billroth's *General Pathology* as in its first, for the slightest mention of the best French labors." After reviewing all that has been accomplished since the last congress, Dr. Verneuil concluded as follows: "Let us give unreserved praise, gentlemen, to the popularization of surgery, so much in keeping with the humanitarian and disinterested spirit of our race. The spread of surgical research in a democratic spirit, without detracting from the merits of the great, will widen the opportunities of the more humble; and the time is not far distant, when enlightened minds, and skillful hands, will be found in the remotest corners of our land. If the French Surgical Congress is enabled to hasten so happy an event, then it will have deserved well of Science and of our Fatherland."

M. Ollier, of Lyons, treated cases of *Ankylosis of the Wrist by Resection*, which left full mobility of the wrist, while at the same time preserving its radial and cubital motor tendons, which were formerly sacrificed. The antiseptic arrangements adopted enabled the operations to be performed without danger. The first case operated on by Dr. Ollier, was that of a young woman, already suffering from a compound osseous ankylosis of the elbow. In this case he resected the carpus and a centimetre of the bones of the forearm, and enabled her to perform on the piano.

Concerning *Ablation of the Larynx*, Dr. Demons, of Bordeaux, says he has successfully performed the operation in the following manner: "I first of all made a transverse hypohyoidian incision, from the middle of which I carried a transverse incision down to a little above the wound left by tracheotomy. I then effected the vertical incision of the thyroid cartilage; a step of the greatest importance, as it enabled me to ascertain that the left side was affected. I consequently determined on total ablation, which was effected, leaving only the cricoid, which I leveled by merely extracting the upper part of its amentum. The operation lasted three-quarters of an hour, and was most successful, thanks to the Trendelenburg canula, to which I superadded an iodoform pad. The after-treatment was of the simplest."

Dr. Dupont, of Lausanne, stated that the danger in the foregoing operation lay in the admission of blood into the respiratory passages. This is obviated by the use of Trendelenburg's canula; the serious inconvenience of this instrument, however, is that a fit of coughing suffices to expel it. Dr. Dupont said he obtained the same result, in a simpler and safer manner, by separating the trachea from the œsophagus, and folding it down forward in the lower angle of the wound, and there fixing it by a suture. This new direction removes it from the axis of the lower extremity of the larynx; and, therefore, the blood flows back of it.

In the operation of ablation, Dr. Molliere, of Lyons, excised one-third of the posterior part of the larynx, and a great part of one of the vocal chords, which he afterwards sought to reconstitute by suture. He completed the operation by a suture of the epiglottis to the cutaneous wound, in order to prevent the passage of food into the larynx. Molliere is in accord with Dr. Demous in recommending his method of operation for well-defined cancer.

The conclusion to be drawn from a long discussion between Drs. Chauvel, Delorme,

Poncet, Reclus, Trélat, Labbé, Nimier, Verchère, Chavasse and Castex, that in gunshot *Wounds of the Intestine*, immediate action of the surgeon offers great chances of success; but that the conveyance of a wounded person, for even a short distance, seldom leaves any hope of averting danger.

PERISCOPE.

The Vaginal Tampon and Its Use.

In an address before the Alumni Association of the Woman's Hospital, Dr. T. A. Emmet spoke of the use of the vaginal tampon in the treatment of certain effects following pelvic inflammations. In the course of his remarks, (*N. Y. Med. Journal*, February 18, 1888) he stated that hot water is invaluable in the treatment of all stages of inflammation involving the cellular or connective tissue of the pelvis, in lymphangitis, in phlebitis, and in the early stages of pelvic peritonitis. On the other hand, he thinks that the vaginal tampon has only been beneficial after all acute symptoms have subsided. If this one feature is not recognized as a cardinal point, the indiscriminate use of this means of treatment will always be attended by unsatisfactory results, and with much unnecessary suffering to the patient. The only cases in the treatment of which he has derived any special benefit from the use of the vaginal tampon have been those in which he has supposed the blood-vessels had degenerated into a varicose condition, and where this state of the veins has been brought about from the effects of local peritonitis with adhesions, from the loss of the connective tissue, and from injury where the fascia has been involved.

In using the tampon we must trust, he says, to the use of the thermometer to show the absence of an elevated temperature in the pelvis, and to the want of other symptoms indicative of existing inflammation. In the absence of other symptoms we must exclude to a great extent the presence of pain on pressure as an evidence of active inflammation, its chief value then being but an indication of the manner in which the tampon should be applied. He holds that the tampon acts mechanically, by compressing the dilated veins and by lifting the uterus to its natural position in the pelvis, so that the circulation between the arteries and veins may be equalized. He has found that by repeated trials that the best material for tampons is the cleanest quality of cotton wool as sold in the shops and put up in rolls. In preparing it he takes a number of pieces of cotton of about the width and thickness of four fingers. He then makes a ball of each by turning the four corners or edges together, and while grasping these he thoroughly smears the outer surface with vaseline. Each ball is then of about the size of an English walnut and keeps it shape as it is packed loosely into a tin box for use. It was found advisable to have these balls of cotton as nearly uniform as possible and of about the size indicated.

On beginning the operation it is sometimes necessary to place the patient on the knees and chest before the uterus can be replaced. Then several balls are to be introduced and placed at a point where the uterus can be held by means of the finger while the patient is turning upon her back. One ball of cotton after another should be placed in the vagina and passed closely along the index finger of the other hand, which is engaged in pressing back the perineum and in holding up the uterus, or that portion of the tampon already introduced.

If one part of the vagina is more sensitive than another we must learn, he says, to "humor" it, by making less direct pressure until tolerance becomes established. When the sensitiveness is situated in the neighborhood of one of the broad ligaments we must pack the cotton on the opposite side of the cervix to act as a crutch. If the inflammation is chiefly about the utero-sacral ligaments, it is easy to tampon so that the uterus will be lifted without making direct pressure. The tampon should be placed so as to make as little direct pressure to the left as possible along the course of the rectum. After the introduction of a sufficient amount of cotton we are to pass the index finger carefully over every portion, to be certain that it is uniformly placed and to smooth down the entire surface. When this "finishing off" is properly done it is possible, from the coherency of the cotton and vaseline, to pack but a portion of the vagina. It may be but the upper part, or to one side, and it is likely to remain in position.

"There are two practical points in the application which, if not carried out carefully, will cause all our efforts to miscarry. The first is to keep the uterus, throughout the whole course of treatment, as nearly as possible in its natural position and at the same plane in the pelvis. The other is to place the fresh tampon without delay after the other has been removed. I have been in the habit of renewing the tampon daily for the patients in my private hospital. But if it could be kept deodorized, the longer it remained undisturbed the more thoroughly

would both of these indications be met in practice."

"The best instrument for removing the cotton is a piece of whalebone with a rough screw cut in the end, a simple device for the application of which we are indebted to the late Dr. Sims. This is easily passed alongside of the finger and twisted into one portion after another. It is well to leave that part directly under the uterus until the last, so that the finger may be slipped beneath the cervix, at the proper moment, to hold it in place until the fresh tampon can be introduced. To facilitate this, everything should be prepared beforehand. It is very evident if the uterus is allowed to prolapse, that just in proportion as it does so the circulation must be disturbed, and that if there is any advantage to be gained from maintaining a steady and uniform pressure, it must be, as nearly as possible, a continuous one. Therefore there should be no unnecessary delay in returning the tampon, as the blood begins again to rapidly dilate the vessels as soon as the pressure is removed."

A serious drawback to the satisfactory progress to be gained by this mode of treatment, says Dr. Emmet, is the recurrence of the menstrual period, when the use of the tampon has to be discontinued. To obviate this, just before the period is expected he removes the tampon and immediately introduces one of the rubber rings of a sufficient size to admit of the introduction of the finger between it and the vaginal wall at any point. These rings are about three-quarters of an inch in diameter, and so long as the patient remains in the recumbent position their broad surface offers a fair substitute for the tampon both in exerting a direct pressure upon the larger vessels and by taking up the slack in pelvic tissues. As soon as the flow has ceased he has a large hot water vaginal injection administered and then employs the tampon as before in the continued treatment of the case.

Traumatic Aneurism of the Orbit.

In the *Bristol Medico-Chirurgical Journal*, December, 1887, A. W. Prichard reports the case of a boy ten years old who was looking through a key-hole on May 23, and while in this position had a piece of umbrella wire thrust into his eye by a boy on the other side of the door. The wire probably penetrated deep into the orbit by the inner side of the eye-ball. A small wound on the conjunctiva and some blood under it towards the inner side, were the most noticeable signs of the injury. A few hours afterwards there was considerable ecchymosis; the globe was almost fixed, moving from side to side only about one-eighth of an inch; this was the cause of double vision; but with that exception, the sight of the injured eye was unaffected. During the first fortnight the ecchymosis was the only symptom; both lids were very dark and the ocular conjunctiva had blood under it. The boy complained very little, and a cold pad was kept generally over the eye. By June 9, however, there was some protrusion noticed, and a faint pulsation could be felt on putting the hand over the eye-ball. On listening with a stethoscope on the eye, a loud bruit could be heard; this was audible all over that side, and faintly over the other side of the cranium. Moreover, the boy complained of a blowing sound in the left ear. Thinking the case was one of traumatic anuerism—or possible of a blood-tumor pressing on the carotid artery, the author for three weeks tried the effect of continuous pressure on the eye-ball with ice around the orbit. This had the effect of ameliorating the diplopia, but accurate measurement from the forehead proved that the protrusion of the globe was increasing.

By July 4 the protrusion had increased so that the injured eye was as much as $\frac{1}{16}$ of an inch in front of the other. There was considerable chemosis and blueness all round the orbit; the bruit was very marked, and pressure on the left carotid entirely stopped it; the boy had headaches and restless nights. Accordingly, after consultation, on July 5, he tied the common carotid on that side at the level of the cricoid cartilage. There was no great difficulty in the operation; the vein was large, and as it were enveloping the artery, and it had to be held carefully out of the way. The vessel was tied with medium-sized catgut, and a small drainage tube put in the wound; the operation was done without a spray. In the evening after the operation no bruit could be heard and no pulsation felt, and the eyeball had receded $\frac{1}{8}$ of an inch. During the next week the boy went on very well. The wound healed very kindly and the eye receded; the double vision was less, and the chemosis and swelling of tissues round the orbit went down. He remained in the infirmary for six weeks after, and to the author's disappointment the bruit returned, and was heard as early as one week after the operation. It was not nearly as loud, however, and was inaudible to the patient himself. The eyeball receded as gradually as it had come forward, and when the patient went out the protrusion only amounted to $\frac{3}{16}$ of an inch. The diplopia was still present, but in other respects the boy was well.

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THE TREATMENT OF INEVITABLE MISCARRIAGE.

Some authors divide the premature expulsion of the ovum into abortion, miscarriage and premature labor. While this is a purely arbitrary classification, it has the advantage of calling attention to the fact, that in general terms the immature ovum is cast off by one of three methods. First, the ovum is cast off entire, the decidua sometimes accompanying, and sometimes following it. Second, the membranes rupture, the fœtus is discharged, and the secundines follow with difficulty. Third, the conditions are analogous to those at term.

During the first two months, when the ovular attachments are slight, the ovum is usually expelled *en masse*, without difficulty, the decidua subsequently coming away in shreds or as an entire membrane. The physician is seldom called on to treat these cases, as the patient is apt to consider the hemorrhage as a delayed and somewhat difficult menstruation. The ovum is usually passed in enveloping clots, and frequently escapes attention. Sometimes the ovum, as well as the decidua, is discharged as detritus. The dangers here, as in all cases of miscarriage, are two—hemorrhage and sepsis. At this early time these are slight. Should serious hemorrhage occur and continue after the use of ergot and the tampon, the case should be treated like one of obstinate bleeding from the non-pregnant uterus, the cavity should be gently curetted with Thomas's curette, and either mopped dry with cotton on an applicator, or irrigated, and have Churchill's tincture of iodine thoroughly applied to its cavity. This application is not caustic, and it is both hæmostatic and antiseptic. Before the third month sepsis is hardly to be feared; it could scarcely be present except by direct infection from the examining finger of the attendant. If present, its treatment would not differ from that of the later months.

Frequently during the third month, more rarely afterward, the ovum is expelled entire. In this form of delivery the hemorrhage is slight, owing to the intra-uterine pressure of the intact ovum. Hence, if on making touch during the third and fourth months the elastic amniotic sac is felt, great care should be taken to avoid rupturing it. Should the ovum be found in the vagina or hanging free in the cervix, it should, of course, be removed. But detachment is a *sine qua non*. Before detachment, officious effort may rupture the membranes and add the greater dangers and difficulties of that form of delivery. Unless the patient be unusually distant from the attendant, with ordinary contraction no treatment is called for. But as the membranes are liable to rupture without warning, and hemorrhage to ensue, under peculiar circumstances a tampon may be introduced as a matter of precaution. Nevertheless, where the physician can visit the patient with reasonable frequency, it should not be used in this class of cases. It needlessly complicates the treatment, and unless strict antiseptic precautions be taken, it increases the liability to septicæmia. Besides, it adds to the discomfort of the patient. Where the process of expulsion is slow, it may be hastened by moderate doses of ergot, a half drachm of the fluid extract every third or fourth hour. The

Faradic current is also recommended to increase the force of the contractions (Grandin). A weak current should be used, one pole being held by the patient, the other passed over the hypgastrium. I have not used the method. The tampon may be used in tedious miscarriage, not for its hæmostatic powers, but for its reflex effect upon the uterine contractions.

When rupture of the membranes occurs, either from criminal operative measures, uterine contractions, or the manipulations of the attendant, two complications are apt to ensue: active hemorrhage, and retention of the secundines. With the collapse of the membranes intra-uterine pressure is reduced, and the ovum no longer acts as a natural tampon—hence the bleeding. The uterus also acts at a disadvantage, thus increasing the liability to retention. It is here that the tampon finds its strongest indication. It should be reinforced by the administration of ergot. All authors agree that to be effectual in restraining hemorrhage it must be well applied. Various materials, such as a sponge, a handkerchief, tow, cotton, wool, or a roller bandage have been recommended. Pledgets of the material selected may be introduced along two fingers as guide, or through a Ferguson's, a bi-valve or a Sims' speculum. The Sims' position and speculum unquestionably offer superior advantages, and should be selected, except under extreme emergency, when time may be all important. Cotton-wool pledgets should each have a string attached, or be made after the kite-tail principle, to facilitate removal. They should be squeezed out of carbolized glycerine and water (1–40). The antiseptic gauze roller-bandage can be substituted for the muslin "roller" recommended by Taylor. It has the advantage of being already prepared, and it is easy of introduction and removal. After irrigation of the vagina with an antiseptic solution, the patient should be put in Sims' position, the perineum retracted, and the tampon applied by packing first the posterior fornix, then the anterior, and last the vagina down to the outlet (the Sims' method.) This may be reinforced by a pad over the perineum and vulva, and a T bandage. After twelve hours the tampon should be removed, although Charpentier advises that it remain twenty-four or even thirty-six hours. Irrigation should always be practiced before touch, as the tampon, in spite of antiseptics, is apt to cause a foul smelling discharge. The fœtus (if not previously passed) and the fœtal envelopes are frequently removed with the tampon, or are found free in the vagina or cervix. Should retention still exist and the os be closed, the tampon should be reapplied. Should this be removed at the end of twelve hours and retention still exist, we are met with the problem as to whether we shall continue the ergot and tampon treatment, or clear out the uterus at once. According to Lusk, Mundé and Playfair, experience fully proves that where the neck is dilated or dilatable the uterine contents can be removed without danger; and the woman is forthwith protected against hemorrhage, and the dangers of sepsis are reduced to a minimum. The French, almost as a unit, and various other authorities, oppose active interference unless symptoms of sepsis or putrefaction occur. Then they interfere in the usual way.

We believe the best rule to be: if, after twenty-four or thirty-six hours' use of ergot and the tampon, the uterus is not empty: empty it. And with each additional experience the temptation grows stronger to follow the more extreme plan advocated by Lusk and others in these cases—to empty the uterus as soon as you can get a finger into it. If the cervix is not dilated, it may be dilated with hard rubber dilators or tents. Engelmann advises the use of slippery-elm tents. The finger is often the best dilator.

The method of emptying the uterus is not indifferent. The finger is necessarily the safest instrument of removal, as it alone is sensitive. Dull curettes of different sizes are safe and efficient in good hands. But a certain amount of experience is necessary to tell when the cavity is clear of the secundines. Lusk truly says that deliberation and perseverance are the main elements of success. Ether is always an assis-

tance, and is often necessary in nervous and primiparous cases. The patient should be placed across the bed, the hips well drawn to the edge; then the index finger is inserted, and made to pass up one side, across the fundus, and down the other side (the nail in contact with the uterine wall), separating the secundines in its progress. The other hand is made to assist by depressing the uterus from above. The *débris* should be removed as far as possible with the finger, and the remainder washed away with the irrigator. After this a fifty-grain iodoform pencil may be placed in the cavity.

From the fourth to the seventh months the fœtus is usually discharged after rupture of the membranes, the placenta and membranes following or being retained. After this time the process of delivery is similar to that at term. Rarely, the ovum is expelled entire. In such cases the treatment does not differ from that of similar cases in the third month. Interference is not usually demanded until rupture of the membranes. Expectancy should be practiced. After the discharge of the fœtus, which at this time necessitates a considerable amount of cervical dilatation, the way is open for the immediate removal of the placenta and membranes. Ergot and the tampon may be used in the fourth month, but after this the danger of concealed hemorrhage overbalances their advantages. The method of removal does not differ from that for the third month, except that we have more room as the pregnancy advances. During the fifth, sixth and seventh months, a modification of Crède's method at term will often succeed, not only in controlling hemorrhage temporarily, but in expelling the uterine contents.

In certain cases, in which the contents of the womb may or may not be considered to have been discharged, we are called upon to treat the consequences of retention. These are the "incomplete" and "neglected" cases. The patient complains of pains, hemorrhage or septic symptoms subsequent to a miscarriage. Where portions of placenta are retained, with sufficient vascular connection to maintain vitality, a polypoid mass results, with metrorrhagia. Where the vascular connections are less, more or less rapid decomposition ensues. The indication to clear out the uterus is the same in both. In the hæmorrhagic cases, ergot will often expel the mass, but the most certain, most surgical way is to dilate the cervix, and remove the mass with the finger, curette, or polypus forceps. The cervix in these cases is often closed, and for dilatation the Wilson steel dilator is the best. After removal of the polyp it is well to gently curette the cavity, and to apply Churchill's iodine. In the septic cases, with foul putrescent discharge, the os is generally open and dilatable. Here, also, the finger is the best implement, but in cases of difficulty there is danger of self-infection. This is an argument in favor of the curette, in these cases. After removal of the retained mass the uterus should be irrigated with hot bichloride solution (1–2000), and
form pencil, of fifty or one hundred grains, introduced. There is commonly a chill, with a sharp rise of temperature, even to 105° F., shortly after manipulation. This is due to increased absorption of septic matter, caused by the abrasions made during the removal of the uterine contents. Unless systemic infection is marked, rapid improvement follows. If otherwise, the treatment does not differ from that of septic infection from putrescent matter *in utero* at term.

It is scarcely necessary to insist, at this time, when the necessity and value of antiseptic precautions in labor are so fully recognized, that the same rigid exclusion of infectious material from the genitals is of great importance. Personal disinfection of the attendant, especially of the examining or operating finger or hand is the greatest desideratum.

OPERATIONS FOR ABSCESS IN THE BRAIN.

At a meeting of the Medical Society of London, March 5, 1888, DR. FERRIER and MR. VICTOR HORSLEY read the notes of a case of cerebral abscess associated with a discharge from the ear, in which Dr. Ferrier diagnosticated the presence of an abscess in the brain and Mr. Horsley operated successfully for its

evacuation. As there are but few such cases on record, this one is of peculiar interest. The patient was a man, 47 years old, who had been ill since November 10, 1887, and on the fifteenth had had an offensive discharge from the left ear. On December 8, when Dr. Ferrier first saw him, he was drowsy, and complained of pain on the left side of the head. He had no paralysis. His pulse was 52, weak and intermittent. His respirations were 14 to the minute, labored and sighing. His temperature was normal. After a temporary improvement, he was at the end of six days more drowsy, and in a few days more he developed some delirium and confusion in his speech. There was also some weakness of the right angle of the mouth.

On studying these symptoms Dr. Ferrier came to the conclusion that the man had an abscess of the brain, probably situated in the anterior part of the third left temporo-sphenoidal lobe, and abutting or pressing upon the fissure of Sylvius. Mr. Horsley agreed in this diagnosis, and, on December 9, he operated by trephining the skull, opening the dura mater, and puncturing the brain with a trochar. The result was the evacuation of about five fluid drachms of odorless pus. After this the patient went on uninterruptedly to recovery.

In commenting on this case Dr. Hughlings Jackson described the result as simply magnificent, and other members of the Society joined in his admiration of the acumen and skill displayed by Dr. Ferrier and Mr. Horsley. Similar feelings must be excited in the minds of all who learn its details; and no one can doubt that to these men the patient owes his escape from impending death.

Operations upon the brain are no longer novelties in surgical experience, and they have been brought into prominence especially by the work of certain German and English surgeons. Among the former, Krönlein stands pre-eminent; and among the latter, Horsley. For a correct appreciation of the indications for, and the technique of their performance one must have a knowledge of the anatomy and physiology of the brain, as well as of the phenomena dependent upon the various lesions of it, and some acquaintance with the details which have been better described by Wiesmann, of Zurich, in the *Deutsche Zeitschrift für Chirurgie*, 1885, than by any single writer with whose work we are familiar.

So far very little seems to have been done in this country in the way of operating upon intra-cranial abscesses or morbid growths, or for the relief of intra-cranial hemorrhage; but the time seems to be ripe for some evidence of the same skill in diagnosis and in operative action, which has of late shed so much lustre upon our brothers in Europe. We may be more fortunate than they are, in the apparent lack of opportunity for imitating their boldness; but it is not unlikely that a better knowledge of what may be known of and done for intra-cranial lesions would lead to the detection of opportunities which now go unrecognized.

SCOTCH OATS ESSENCE.

In the number of that outspoken journal, the *Boston Journal of Health*, for March, 1888, there is an article which discusses the character of so-called Scotch Oats Essence, and in which the statement is made that it contains about thirty-five per cent. of alcohol by measure. This statement is placed in contrast to that of the makers and advertisers of this preparation who assert that it is an absolutely harmless vegetable tonic, which will free the victim of the alcohol habit from his terrible bondage.

This interesting contribution to the literature of the Scotch Oats Essence has been followed up by an article in the *Druggists Circular* for April, in which the statement is made that this Oats Essence contains morphine. A careful quantitative analysis disclosed the fact that a bottle contained more than two grains of this alkaloid.

The information secured and published by the two journals mentioned is of great importance to all medical men; for it is not long since this special preparation was advertised in a large number of medical journals, and probably secured some recommendations from members of the medical

profession. At the present time the manufacturers are making continuous and strenuous efforts to secure a large sale for it, and they have not hesitated to proceed by methods which recently resulted in an action being brought against them for the misuse of the name of a well-known physician in New York. It is well, therefore, that medical men should be on their guard against this so-called tonic, and take pains that there shall be no doubt as to their attitude toward a preparation which is claimed to be absolutely harmless, and yet contains such considerable quantities of alcohol and morphine. It is time that physicians took a more active part in suppressing some of the frauds which, in the guise of medical treatment, are practiced on the community; and if the allegations in regard to Scotch Oats Essence are true, it is a first-rate fraud to begin on.

In this connection, we take pleasure in recommending to the appreciation and gratitude of our readers the two journals named above, which are doing such service in investigating and disclosing to the public the ingredients of a number of much-advertised nostrums. Such service is rarely rewarded as it deserves, but it shall not miss whatever recognition the REPORTER can give it.

ANTI-ADULTERATION BILL.

The United States Senate has just passed a bill, introduced by Mr. Edmunds, providing for an inspection of meats for exportation, and prohibiting the importation of adulterated articles of food or drink. It seems that this bill has been introduced and passed in order to give the President power to exercise the pressure of retaliation upon European countries which have excluded certain articles of food—notably pork—sent out from America, on the score of unwholesomeness, but perhaps really because they competed too strongly with products of their own peoples.

But whatever may have been the motive prompting the Senate, it is pleasant to note that a beginning has been made in this important matter. The present bill provides for a government inspector of meats designed for exportation, and forbids the importation into the United States of any adulterated food or liquors. It gives to the President ample power to enforce its provisions against any country from which adulterated articles are imported, and, if carefully carried out, cannot fail to prove of great advantage. It may, and we sincerely hope it will, prove but the beginning of broad and wise measures for the protection of the public health. If the Constitution of the United States does not justify the exercise of such a paternal authority in matters of health as is in force in less democratic countries, we trust that Congress may at least exercise the prerogative of initiating some general movement among the States, so that all over the country there shall be uniform laws protecting the public health.

PENNSYLVANIA STATE MEDICAL SOCIETY.

The time for the next meeting of the Medical Society of the State of Pennsylvania (June 5) is approaching, and it is desired that the programme shall be completed as soon as possible. For this reason, gentlemen who intend to read papers are urged to send their names and the titles of their papers at once to Dr. John H. Packard, of the Committee of Arrangements, 1924 Spruce street, Philadelphia. The time to which applications for a position on the programme is limited, is April 15.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the REPORTER.]

DISEASES OF THE SKIN. By JOHN V. SHOEMAKER, M.D., Professor of Skin and Venereal Diseases in the Medico-Chirurgical College of Philadelphia. New York: D. Appleton & Co.

Considering how little we have advanced in our knowledge of the etiology and pathology of the different skin diseases since the time of Hebra, it is somewhat astonishing to how many exponents in the form of manuals and text-books the intervening years have given birth. For so young a specialty its workers are apparently both numerous and zealous, although of late the most energy has been directed in therapeutic channels. The book before us is the third large octavo volume in this branch which has appeared in the past several months.

This treatise in its general arrangement and descriptions resembles closely those which have preceded it; in fact, its arrangement is almost identical

with that adopted by Duhring. In a few respects, the author swerves from the usual classification, evidently following in this respect "Robinson's Manual." Lichen planus and lichen ruber are considered, for alleged pathological reasons, as distinct diseases, and not as different phases of the same process as generally accepted. The first is placed under the inflammations, and the latter under hypertrophies. The correctness of this view, however, has been denied by other investigators. Psoriasis has been transferred from the inflammations to the hypertrophies. This tendency to reclassify, upon individual investigations alone, does more to mystify than to aid in the advancement of our knowledge. Classification depends upon the sum of our information, and although all data are valuable as tending toward a clear understanding, until more or less unanimity obtains a new departure is scarcely justifiable. In the present instance, therefore, the author does not carry out his intention as expressed in the preface "that the whole work has been written from the standpoint of an active general practitioner, and can hardly fail to bear that impress." The chief complaint of the general practitioners against dermatologists has been the incessant and confusing changes in the names and classification. It will be difficult to explain intelligibly to the general practitioner, with the inflammatory signs of psoriasis before him, that the disease is a hypertrophy, and it is only just to the general medical public to add that as yet such a view of the disease is far from accepted by the dermatological world. The author offsets this slip, however, in incorporating in the work a consideration of the cutaneous symptoms of the exanthemata. We believe that such should find a place in every text-book on diseases of the skin. No mention is made of the disease, or group of symptoms, known as dermatitis herpetiformis. Under this or another name these cases demand recognition.

So much has been written by Dr. Shoemaker in regard to the therapeutics of skin diseases, that naturally this part of the work was expected to be the strongest, but on the contrary it is disappointing, although in many respects original. The oleates are still in favor with him, although, with few exceptions, they have after trial failed to find a permanent place in the therapeutic resources of those specially engaged in dermatological practice. The author states his confidence in sulphur as one of the most valuable remedies in the external treatment of chronic eczema. This is contrary to general experience. It is true, it is useful in certain cases, but the number is extremely limited; in most instances it will be found to aggravate, and under all circumstances should be employed cautiously. On the other hand, the author refers but briefly and subordinately to the usefulness of sulphur and its preparations in acne and rosacea. In sycosis, also, the same remedy is scarcely mentioned, although beyond doubt, when judiciously prescribed, it is the most valuable in the whole list. In short, if we take him at his word, the author is able to cure his cases on lines of treatment quite different from those usually adopted by dermatologists.

The micro-photographs which accompany the text are excellent; the colored plates, with one or two exceptions, are simply atrocious. With this exception, the publishers' part of this book is well done.

—Numerous foot-ball accidents in the way of broken limbs are being reported by the English journals.

MODERN TREATMENT OF HEADACHES. By Allan McLane Hamilton, M.D. 5½ x 7 inches, pp. 124. Detroit: Geo. S. Davis, 1887. Price, 25 cents.

This book is the November number of the "Physicians' Leisure Library." It contains an excellent account of the different varieties of headaches and very valuable suggestions in regard to their treatment. The author sends it out with a modest preface; but we believe it is a book calculated to be of great service to every physician. We are glad to be able to speak more favorably of it than we have done of some of the numbers of this series, the design of which is good, whilst its execution has thus far been very unequal. We must, however, call attention to some defects which we presume are chargeable to the proof-reader; for we cannot believe, for example, that Dr. Hamilton would be guilty of the errors which are to be found in his prescriptions as printed in this book. These errors, it must be stated, do not affect the value of the formulæ, although they will offend those who respect accuracy of statement and correct spelling. The book is a good book, and may be safely recommended to our readers; but before it goes to a second edition the errors we refer to ought to be eliminated from it.

Pamphlet Notices.

Medical Organization. By A. N. Carrigan, M.D. From Transactions of the State Medical Society of Arkansas. 4 pp.

—Dr. Carrigan, who has died since he read this paper at the twelfth annual session of the Arkansas Medical Society, makes in it, an earnest plea for the formation and hearty support of county medical societies. These he regards as the starting-point for advancement in the republic of medicine, and as a great means of education and cultivation in the art of medicine.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—*Babyhood* for March continues the useful work which this magazine began about three years ago. It contains much valuable information for parents, especially mothers, and for intelligent nurses. By far the best part of this is that contained in the editorial departments, while the original articles are very good, even if some are a little too technical for the nursery.

—The *Boston Journal of Health* is a wide-awake, interesting and useful monthly, each number containing about sixteen large quarto pages. Subscription price, $1.00 a year. Just now it is exposing with great vigor the claims of a number of quack remedies. The number for February devoted considerable space to an analysis of what is known as "Murdock's Liquid Food," and the number for March follows this up with a refutation of what appears to be a rejoinder. This sort of thing makes interesting reading, and, we believe, is calculated to do much good.

CORRESPONDENCE.

Prescribing Druggists.

EDITOR MED. AND SURG. REPORTER:

Sir:—Although not a doctor, nor even a "prescribing" druggist, I am a constant reader of the REPORTER, and have been for a number of years. I have just read the tirade of B. P. Reese in the last issue, and wish to protest against his wholesale denunciation of druggists, because he has cause of complaint against a few black-sheep in the fold of pharmacy; I do not offer any excuses for, nor uphold "prescribing druggists." Like "rum" drug-stores, there is no excuse for them.

But who are the prescribing druggists? Nine out of every ten are like the particular one referred to by Dr. Reese, *i.e.*, M.D's. engaged in the drug business; not pharmacists, nor chemists, but simply doctors assuming a profession that they are not as capable of filling as the average pharmacist is of prescribing for a cough, cramp in the stomach, or other minor complaint. We would like the doctor to suggest some way to teach physicians "to confine *themselves* to their legitimate business," and stop the growing evil of overcrowding our business, or we will be compelled to get an M.D. diploma and practice medicine ourselves.

It is not a fact that "druggists do all in their power to deprive the physician of his fee." On the contrary, as a class, we are always willing and glad to extend to the physician such help and professional courtesy as we can. The M.D. druggists may, and do, absorb the total fees; but there is no way nor use of retaliating, as not many of them have much prescription business outside of their own practice, so that a "boycott" will not remedy the trouble.

Has a doctor, or anyone, a right to prescribe for a patient he has not seen or examined? Preferably not; yet observation shows that not less than half of the prescriptions for coughs and the minor ailments are written by physicians in good standing, on the word of another without seeing or examining the patient. Would you deprive your brother in the profession of the same privilege because he is engaged in the drug business?

Aside from ethics, there is a legitimate demand among the poor and those of limited means, who are not able to fee a doctor for every "grunt," for cheap remedies for those ailments, as evinced by the frequent calls for "a nickel's worth of hive-syrup, paregoric, Brown's mixture, etc.," and the number of "receipts for cough syrup" of domestic origin, as well as the demand for "patent medicines." Should not a pharmacist be as competent to prescribe a good cough syrup, or worm powder as a doctor who has not seen his patient, or the patent nostrum maker? This demand will always exist, and if not supplied by the druggist, it will be by the grocer or dry-goods man. You may legislate at it, and control it by inspection, as should be done with proprietary articles; but you can't stop it any more than you can prevent a mother from giving catnip tea or paregoric to a sick baby, or the mechanic from filling a fresh wound with tobacco juice.

There are just causes of complaint on both sides, and there is no use in denouncing your co-workers as a class because a few offend. "Let us have peace."

Yours truly,

Sharon, Pa., A. L. BECK, PH. G.
March 17, 1888.

A Physician's View.

EDITOR MED. AND SURG. REPORTER:

Sir:—I notice in the REPORTER of March 10, an article from B. P. Reese, of Virginia, on the "Prescribing Druggist." This subject is one, owing to the crowded condition of the ranks, that should elicit the attention of the medical profession. It is very obvious that the druggists are, through this medium, annually taking many thousands of dollars that belong to the physicians. The notion of the people in going direct to the druggist to prescribe for their chronic aches and pains is truly an unnatural state of affairs. Nevertheless, custom has established this notion in the minds of one-half, if not more, of the people, and they do it, and will continue so to do, irregardless of all the laws the Legislature can pass. One-half, at least, of the people do not comprehend the value of a correct diagnosis, and they absolutely realize the fact that the physicians, as a rule, don't handle medicines, but only give prescriptions; consequently, as they don't place the proper value on advice and prescriptions, it is a minor matter with them; and with the view of saving the charges for such they go direct to the druggist, and leave the physician out of the deal, and it is not very often that the druggist sends them back to the physician; but he caters to please them, and that in his own interest, amply supplied with the remedies suited exactly to his own peculiar business, such as syr. hypophosphites, liquid lactopeptine, bromo-caffeine, and many others that could be mentioned,

and so moves the business. Now, the law to stop this resides within the medical profession, proper. Let each physician keep and compound his own remedies for his patrons, and the result will be: in place of the people going to the druggists, they will go to the physician; his office practice will be increased; it won't take the number of patrons that it does at present to support each physician; the people will be better satisfied; the dignity of the profession not a bit lowered, and its power to protect its own interest greatly increased.

Yours truly,

CHARLES W. MUSGROVE.

Austinville, Pa.
March 20, 1888.

Statistics of Consumption.

EDITOR MED. AND SURG. REPORTER:

Sir:—In the MEDICAL AND SURGICAL REPORTER for March 24, 1888, there appears an interesting though deceptive article from the pen of Dr. Sozinskey, entitled *Sex in Consumption*, which is tacitly intended as a refutation of the deductions in my paper on *Female Dress as a Determining Factor in Pulmonary Consumption*, and published in the *Medical News*, January 7, of this year. In this paper I maintain that the female is less liable to pulmonary consumption than the male, because she possesses a greater apical expansion; and had I not taken for granted in its preparation—though it appears without sufficient justification—that the absolute worthlessness of the United States census reports for securing reliable mortality statistics is universally known and admitted, this brief reply would indeed be entirely unnecessary. Any one who has had the least intelligent experience in gathering vital statistics knows full well that no data exist in this country which are worth computing except those coming from the larger cities, and perhaps from one or two of the smaller States. Outside of these sources no pretensions are even made to collect reliable mortality statistics save by the census-taker, who comes around and guesses at them every decennium. In proof of this assertion, and for the benefit of the few who still persist in hugging the delusive phantom that the census statistics are immaculate, I beg to quote the language of Prof. Francis A. Walker, Superintendent of the Ninth Census, and whose authority on this point is unquestionable. He says: "The failure of the census to reach the object proposed is perhaps nowhere so conspicuous as in the returns of the deaths occurring during the census year. The reasons for this comparative failure are not obscure or remote. Statistics of mortality can only be satisfactorily obtained as the result of a system of registration maintained without interruption and rigidly enforced by penalties. In the census of the United States, on the contrary, it is sought by an occasional enumeration to recover information of all the deaths which have occurred during the twelve months preceding. It is not wholly a matter of blame to the agents of the census that such an effort results in the return of but 60, 65 or 70 per cent. of the deaths which we know must have occurred during the period covered by the inquiry.—(The Relations of Race and Nationality to Mortality in the United States. Reports of the American Public Health Association, volume I., page 18).

It would be simple madness to anticipate anything satisfactory from such sources, and therefore I addressed myself to an examination of the health reports of all the American and foreign cities to which I could gain access, knowing that they have *a system of registration maintained by rigidly enforced penalties*, such as is described by Professor Walker, and under these circumstances I I think it requires but little "acuteness and strength of wit" to decide whether Dr. Sozinskey's figures or my own are spurious or real.

The conclusions presented in my paper I consider irrefutable so far as I know at present, and I furthermore feel quite certain that, in order to assail them successfully, a stronger armament is needed than a few quotations from the United States census report.

Yours truly,

THOMAS J. MAYS, M.D.

Philadelphia, March 26, 1888.

—Dr. O. Barbacci reports to the *Centralblatt f. d. med. Wissensch.*, the result of his estimation of the hæmoglobin with Fleischl's hæmometer in twenty-eight cases of decided chlorosis. He finds the average percentage of hæmoglobin about 44 per cent. of the normal, varying between 39 and 50 per cent. After the employment of iron for from two to four weeks an increase of the quantity of hæmoglobin to the extent of 10 to 30 per cent. occurred regularly, along with the improvement in the general health. This condition then usually continues stationary for a long time, but even in slowly progressing improvement the normal quantity of hæmoglobin is never attained.

Notes and Comments.

Malarial Congestion.

In a paper read before the Tri-State Medical Association of Mississippi, Arkansas and Tennessee, Dr. J. A. Lipscomb, of Memphis, stated that 10 per cent. of the deaths in Memphis during the months of July, August and September were caused by malarial congestion. He believes that the difference between the ordinary and the congestive, or pernicious paroxysm, is only one of degree. Cases classed as congestive may be arranged, for practical purposes, under one of the five following groups: the comatose, the spasmodic, the pulmonary, the choleraic and the algid. In the first group the poison seizes upon the brain; in the second upon the cord and medulla; in the third upon the respiratory organs; in the fourth upon the digestive organs, and in the fifth upon no special more than another, unless it be the skin. The leading indications are to bring about reaction, and then to bring the system as speedily as possible under the influence of an antiperiodic. He freely concurs in the following opinion expressed by Dr. Davidson:

"No time is to be lost in relieving the patient from the lesion of innervation and bringing about reaction. Delay in experimenting with sinapisms, plasters and stimulants is time thrown away, and will disappoint the expectations of the physician."

Dr. Lipscomb then declares: "While the depressed condition of the heart's action continues, with the serum of the blood exuding through the paralyzed capillaries of the whole mucous surface of the bowels, and the copious transudation through the skin exhausting the patient and deepening the collapse, calorification is difficult to restore. All means therefore for arousing the energy of the nervous system, and thus restoring the lost tone to the tissues, must be resorted to. What then are the means best adapted to these ends? In my humble opinion, the shock produced by the cold douche, conjoined with the hypodermic injection of morphia and atropia, or of strychnia, or of atropia and digitaline, as the indications may require."

As to the best way of applying the cold water, he has adopted the plan of pouring it from the pitcher, held as high above the patient as is convenient and allowing it to fall directly upon the back of the head and neck and down the spine. After having used several gallons of water in this way, he has the patient wiped dry with towels and wrapped in dry blankets, and given a hypodermic injection of atropia, or of atropia and morphia, or of strychnia, as may seem to be indicated. If reaction does not take place in half an hour, he repeats the douche, and wraps the patient in the blankets as before. If there is great restlessness with vomiting, morphia and atropia subserve the best purpose; if great nervous depression with sighing respiration, strychnia increases the muscular tonicity and stengthens the action of the heart, as does also digitaline.

If by these means, he says, you have succeeded in establishing reaction, lose no time in meeting the second indication, namely, that of bringing the system under the influence of quinine. He cautions the physician, however, against letting anxiety to meet the second indication get the better of his judgment, and so commence the quinine too soon. Before reaction is established and the nervous centers liberated from the depressing effect of the poison, quinine will add to the depression and sink the patient into a condition of collapse from which it will be difficult to relieve him, even if it can be done at all. He is satisfied that he has seen this happen more than once in his own practice, as well as in that of others. Having thus succeeded in establishing reaction, he advises to proceed at once to meet the second indication by the administration of quinine. The preparation of the remedy and the avenue by which it is to be administered, so as to most speedily bring the system under its antiperiodic effect, he regards as matters of grave importance. It does no good to give it by the mouth—for if it is not rejected it will not be absorbed; and the same objection may be urged to giving it by the rectum. The hypodermic method he regards as the only one to be thought of, and the bisulphate, being the most soluble, as the best preparation. One drachm of of this salt dissolved in an ounce of hot water and filtered makes a very nice solution and is less often followed by abscesses than a solution of the sulphate. One drachm of this solution representing seven and one-half grains may be injected under the skin every hour or two as the exigencies of the case may require. Since adopting this plan of treatment he has had better success than with the old one, and thinks he has saved some valuable lives.—*Memphis Med. Monthly*, March, 1888.

Salts of Nickel.

The use of nickel and nickelled utensils tends to spread more and more. M. Van Homel Ross, having recognized by various

physiological experiments, the innocuity of this metal protests against a decision of the Superior Council of Hygiene in Austria, tending to prohibit the sale of nickel cooking utensils. Dr. Blayae read the work of this learned chemist at a recent meeting of the Academy of Medicine of Paris. The opinions of chemists differ. Orfila decides neither one way nor the other; Hussel, declares that nickel is more dangerous than iron; Simpson, compares it to zinc or tin, with regard to its poisonous properties; Anderson considers it as dangerous as and similar to picrotoxine; Dragendorf declares that it is a very dangerous substance, and says that a dose of a single milligramme of acetate liquifies the globules of the blood, and destroys them. Professor Riche has made several experiments on guinea-pigs administering acetate in large doses. One died immediately of pneumonia as confirmed at the autopsy by Dr. Laborde, the other is quite well. A dog felt no ill effects after having received 25 grammes of the same salt at the rate of 50 centigrammes per day; on another dog, the dose of 50 centigrammes had no effect; it was then increased to 75, to a gramme and 2 grammes. At this last dose the animal did not die but was taken with vomiting, a chronic diarrhœa, and a sort of ataxy of the hind quarters. The symptoms disappeared rapidly when the dose of the salt was decreased to ½ gramme and the animal, which had become thin, soon fattened up again. The animal was killed and the autopsy proved there was no trace of injury. It is impossible to decide from the dog to man, but what has been shown in the course of this last experiment goes to prove that the extremely small quantity of nickel salts entering into substances cooked in vessels of this material has no hurtful effect. Nickel employed in cooking is not more dangerous than iron, which it approaches in its chemical composition.

Art in the Home from a Medical Standpoint.

Dr. I. N. Love says: "I would sooner hang in my home a ten cent chromo of a cheerful and pleasant subject, than the grandest creation of a Gabriel Max, if it present the horrible side of life as does his "Infanticide." Hanging scenes and revolting representations of morgues, may be very artistic in that they are true to nature; and even though it may be true, as has been stated (though I doubt it), that art has nothing to do with morality or immorality, I believe their proper place along with the nude in art to be art galleries and museums. And I consider anatomical and pathological pictures with skulls and skeletons as part of the belongings of a medical college, or of the inner hidden closets of the doctor's office. They are of the shop, shoppy, and in exceeding bad taste when exposed to the view of patients.

It may be true that the nude in art has rendered holy the beauty of woman and the strength of man; but I question the propriety of placing before the eyes of the undeveloped, uncultivated, or non-professional, much in the way of nude in art, just as I would hesitate to open a male and female surgical clinic to the gaze of children or a lay public."—*Weekly Med. Review*, March 17, 1888.

Influence of Obesity in Young Women upon the Menstrual and Reproductive Function.

In a paper read before the Medical Society of the State of New York, February 7, 1888, Dr. Andrew F. Currier, concluded from the testimony presented, that obesity occurring in young women caused disordered menstruation, and usually sterility, whether the patient had previously borne children or not. If utero-gestation were completed in such patients the child was likely to manifest deficient vitality. The quantity of the flow was almost always less than normal, of abnormal quality, the duration a few hours or a day. Pain was an almost constant symptom. It was in the sacral region in nearly all cases. Vicarious menstruation was common. Constipation was usually present. There was often an hereditary predisposition to early obesity. It might be brought on by luxurious habits, sluggish disposition, passive sexual indulgence, free use of starchy and saccharine foods. Suggestions as to treatment were based on the etiology.—*N. Y. Med. Journal*, Feb. 11, 1888.

Mouth-wash.

The *Chemist and Druggist*, March 17, 1888, says a teaspoonful of a lotion prepared according to the following formula, in a wineglassful of warm water, used every morning as a mouth-wash, is good for restoring firmness to the gums when the teeth are loose:

Tannin	1½ drachms
Iodide of potassium	12 grains
Tincture of iodine	1 drachm
Tincture of myrrh	1 drachm
Rose-water, to	6 oz.

Dissolve the tannin and potassium iodide in the rose-water. To this add the tinctures, and strain.

Compulsory Vaccination.

The following quotation from *The Sanitarian* would seem to indicate that a compulsory vaccination law has its advantages: "The success of the anti-vaccinationists is aptly shown by the results in Zurich, Switzerland, where for a number of years, until 1883, a compulsory vaccination law obtained, and small-pox was wholly prevented (not a single case occurred in 1882). This result was seized upon in the following year by the anti-vaccinationists, and used against the necessity for any such law, and it seems they had sufficient influence to cause its repeal. The death returns for that year (1883) showed that for every thousand deaths two were caused by small-pox; in 1884, there were three; in 1885, seventeen; and in the first quarter of 1886, eighty-five."

Wart-Charming Extraordinary.

A well-known and old-established firm of chemists in Birmingham, England, is doing a lucrative trade in charming away warts. The *modus operandi* is somewhat novel. The principal partner in the business gravely examines the warts, counts them, and instructs the patient to depart and return in a week's time. The order is obeyed, and when the individual makes his appearance on the second occasion, the chemist places on each wart a piece of bacon which he has prepared in the interim, indulges in a solemn incantation, tells the patient he must not thank him, and quickly walks away. The warts are said to wither away in the course of a few days afterwards. —*Chemist and Druggist*, Feb. 4, 1888.

The Philadelphia Polyclinic.

The remaining evening lectures in the Polyclinic course will be given on the following dates at the Polyclinic building, Broad and Lombard streets.

April 10.—Prof. Arthur Van Harlingen: The Management of Eczema in Old People.

April 20.—Prof. J. Henry C. Simes: The Treatment of the Primary Lesions in Syphilis.

April 24.—Prof. Edward Jackson: The Character and Significance of the Retinal Lesions Associated with Bright's Disease.

May 1.—Prof. Alexander W. MacCoy: Observations on the Pharyngeal Tonsil.

May 11.—Prof. H. Augustus Wilson: Treatment of lateral Spinal Curvature.

May 22.—Prof. Solomon S. Cohen: Respiratory Therapeutics.

Medical Association of the State of Alabama.

The Medical Association of the State of Alabama will hold its annual session at Montgomery, Alabama, beginning *Tuesday, April 10*, in the U. S. Court Room (P. O. Building), where the secretary and treasurer will be in attendance every morning. The first day's meeting will be largely taken up with business matters, but will include an Address of Welcome by Dr. W. G. Gibb; the Annual Message by Dr. E. H. Sholl; and the Annual Oration at 8 P.M., by Dr. B. J. Bodwin.

Wednesday, April 11.—Morning Session.—The following papers will be read:

The Value of Exploratory Incisions—William Locke Chew, M. D., Birmingham; The Radical Cure of Hernia—Luther Leonidas Hill, M. D., Montgomery; The Practical Investigation as to the Therapeutic Value of Salicylate of Hydrargyrum—Henry Tutwiler Inge, M. D., Mobile; Studies in Eczema—Arnold Jolly, M. D., Linden; Electricity in Uterine Diseases—Mortimer Harvey Jordan, M. D., Birmingham; Physiological and Pathological Heredity—James Thos. Searcy, M. D., Tuscaloosa; Diarrhœal Diseases of Children in Western and Middle Alabama—William Henry Sledge, M. D., Livingston; The Medical Topography of Walker County and its Prevailing Diseases—Alexander McAdams Stovall, M. D., Jasper; Color Blindness and Defective Vision in Relation to the Traveling Public and the Railroads—Robert Dickens Webb, M. D., Birmingham; Studies in Rectal Surgery—Benjamin Leon Wyman, M. D., Birmingham.

Evening Session.—Discussion of the best methods of administering the health laws, and the law to regulate the practice of medicine.

Thursday, April 12.—The Omnibus Discussion—Milton Columbus Baldridge, M.D., of Huntsville, leader. Topics: 1st. Typho-Malarial Fever. 2d. Hereditary Diseases. 3d. Influenza. 4th. Pain as a Symptom of Disease. 5th. The Knife in Uterine Surgery; its uses and abuses. 6th. The Medical Treatment of Old Age. 7th. Rheumatism and Gout.

Certificates are placed in the hands of ticket agents, who will furnish them to delegates and others upon application at the time tickets for the going journey are purchased, but *no refund of fare will be made on any account whatever because of failure of the parties to obtain certificates.*

NEWS.

—Cholera is still prevalent in Chili, and fears are entertained lest it may also pass the boundary into Peru.

—It is reported that Professor Fritsch, of Breslau, is to be offered the chair of midwifery at Würzburg, made vacant by the death of Scanzoni.

—The St. Louis Medical College held its annual commencement, March 8, and graduated sixteen men as physicians, and one hundred and thirteen as dentists.

—The Twentieth Annual Session of the Texas State Medical Association will be held in the city of Galveston, beginning Tuesday, April 24.

—The oldest man in Germany is called Wapniarek, and lives at Hutta, near Gresen, in the province of Posen. He was born in 1764, and is consequently now in his 124th year.

—Deaths from small-pox and yellow-fever still continue to occur at Havana, Cuba. For the week ending March 17, there were twenty-one deaths from the former disease, and three from the latter.

—An Act has passed the Iowa Assembly which requires druggists to label every package of poison they sell with two antidotes to the drug, as well as the word "poison," which is now placed on every such package.

—Dr. D. W. Cullimore states in a letter to the *Medical Press and Circular*, March 14, 1888, that he has obtained very good results in the diarrhœa of locomotor ataxia from the use of cocaine by suppository.

—French pharmacists are anxious to make and dispense antipyrine without bringing themselves into conflict with the German patents, which control its manufacture under that name. It has been suggested to make and dispense it under its proper chemical name (*dimethyloxyquinizine*), which would be awkward, or as *analgesine*.

—The *Popular Science Monthly*, April, 1888, says that Mendeljeff has, by a study of specific gravities of mixtures of alcohol and water, arrived at the conclusion that there are three definite hydrates, containing respectively three and twelve molecules of water to one molecule of alcohol, and three of alcohol to one of water. The first of these has been obtained in the crystalline form at the temperature attained by a mixture of solid carbon dioxide and ether; the second solidifies at—17°.

HUMOR.

A MAN IN A PRAYER-MEETING once prayed for the absent who were "prostrated on beds of sickness and sofas of wellness."

"THE DOCTOR SAID he'd put me on my feet again in two weeks." "Well, didn't he do it?" "He did, indeed; I had to sell my horse and buggy to foot the bill."

DOCTOR—WELL MY DEAR SIR, what seems to be the seat of your disease? Patient—It doesn't seem to have any seat, doctor. It's just jumping up and down all the while.

YOUNG MAN (AIRILY)—Excuse me, but haven't I seen you face before? Colonel Scrap (who suffers from dyspepsia)—Quite likely; I've never worn it behind.—*Life.*

OBITUARY.

THOMAS B. CURLING, F.R.C.S.

Mr. T. B. Curling, who was for many years surgeon to the London Hospital, died at Cannes, March 4. In a paper presented at his instance to the Royal Medical and Chirurgical Society, in 1846, Mr. Curling spoke of the possibility of seeing the fundus of the eye, and of the usefulness of such investigation as an aid to diagnosis. The paper thus anticipated the ophthalmoscope.

WILLIAM B. GOLDSMITH, M.D.

Dr. William B. Goldsmith, Superintendent of the Rhode Island Butler Asylum for the Insane, died at Providence, March 21, in the thirty-fourth year of his age. He succeeded the late Dr. Sawyer as Superintendent of Butler Asylum two years ago. He was graduated at Amherst College, and was educated for special practice in insanity. He passed two years in hospitals in London, Edinburgh, and Germany, and began professional practice at the Bloomingdale Asylum, New York, under Dr. Nichols. When twenty-eight years old he was called to the Superintendency of the hospital in Danvers, Mass., and stayed there until invited to go to Providence.

Official list of changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from March 25, 1888, to March 31, 1888:

Major J. P. Kimball, Surgeon, granted leave of absence for two months, to take effect about April 10, 1888. S. O. 68, A. G. O., March 23, 1888.

First Lieutenant W. D. Crosby, Assistant Surgeon, granted leave of absence for two weeks. S. O. 29, Dept. Ariz., March 16, 1888.

Captain Thomas F. Azpell, Assistant Surgeon (retired). Died March 12, 1888, at Fort Lee, N. J.

There have been no changes in the Medical Corps of the Navy, for the week ending March 31, 1888.